Anglia Care Homes Limited

Bellevue Residential Care home

Inspection report

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22 February 2018

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Bellevue Residential Care Home is registered to provide care and support for up to ten older people. The service supports people living with a diagnosis of dementia and or mental health needs.

The last comprehensive inspection of this service was undertaken in March 2017. We identified a number of breaches of the legal requirements and found that people were not sufficiently protected against risks, the premises were not clean and there were not always sufficient staff available to support people and meet their needs. After the comprehensive inspection, the provider told us that they were addressing the concerns and we subsequently met with them to discuss the actions that they were taking. We undertook a focused inspection on 28 November 2017 to check that the provider had followed their action plan and to confirm that they now met legal requirements. We found that they had not addressed the issues and were still not meeting the regulations. We rated the service as 'Inadequate' and Bellevue went into 'special measures'.

Following this focused inspection we placed urgent conditions on the provider's registration with the aim of driving improvement. These conditions meant that the provider was unable to admit any new people into the service and they had to ensure that there was sufficient and suitable food available to meet people's needs. Appropriate referrals were to be made to health professionals for advice and guidance. We required the provider to commission an independent review of training and health and safety to address some of the issues we found.

This inspection on 21 and 22 February 2018 was unannounced and we planned to check on the progress the provider had made. It was also prompted in part by information we received which indicated that people's needs were not always being met.

There were ten people living at the service on the day of our inspection. This report only covers our findings in relation to Safe and Well led. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bellevue Residential Home on our website at www.cqc.org.uk"

The service had a registered manager who was also a director of the company which owned the service. The registered manager was also registered to manage another care home for older people in Clacton which they also owned. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found that sufficient progress had not been made and the provider continued to be in breach of multiple regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Practices at the service did not protect people and there was a lack of understanding of the causes of behaviour and how people's distress should be managed. Staff did not always support people in the least

restrictive way possible and in way that promoted their wellbeing.

There were some risk assessments in place but these did not adequately address risk and staff were not always aware of, or followed the management plan. We identified issues with moving and handling, the support provided to people with catheters and those at risk of aspiration or choking. Following the inspection we asked the registered provider to take urgent action to protect people and we raised our concerns with the safeguarding team at the local authority.

Environmental risks continued not to be well managed and we identified that issues were not always addressed in a timely way. We identified continued issues with the management and oversight of medicines. Staff were not always following the recommended guidance and we were not assured that people always received their medicines as prescribed.

At the inspection we found continued issues with the competency and availability of staff which meant that people continued to be at risk of poor care. Staff did not demonstrate that they had sufficient levels of training or expertise to meet the complex needs of the people living in the service. Staff morale was low and they did not feel supported.

There were quality assurance systems in place but these had not been effective in driving change at the service. Sufficient improvement had not been made since our last inspection.

The overall rating for this service remains 'Inadequate' and the service remains in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures

Following the inspection CQC reviewed the concerns and took appropriate action. There is no one currently living in the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe.

Risks to people's welfare were not managed effectively. Staff did not always support people in the least restrictive way possible and in way that promoted their wellbeing.

Care staff were not equipped with the information to safely support people with behaviours that challenged in a way that protected their dignity and freedom

There was not always sufficient skilled and knowledgeable staff deployed to meet the needs of people living in the service

People did not receive their medicines as prescribed. Medicine administration was not safe and did not always follow professional guidance.

Is the service well-led?

Inadequate

This service was not well-led.

Leadership at the service had not been effective in driving improvement

Sufficient controls were not in place to mitigate the risks to people's safety

Audits had not addressed the shortfalls we found or promote individualised care.

Bellevue Residential Care home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by information received about how risks at the service were managed. This inspection was unannounced and focused on the areas of Safe and Well led.

Two inspectors undertook the inspection on the first day of the inspection and one inspector on the second day. Prior to our inspection we reviewed information we held about the service. This included any statutory notification that had been sent to us. A notification is information about important events which the service is required to send us by law. We also spoke with the quality team at Essex County Council about their visits to the service.

We spoke with four members of staff, a member of staff who had recently left, the registered manager and the management consultant. We observed how people were supported throughout the day of the inspections. We reviewed care and support plans, medication administration records, staffing rotas and records relating to the quality and safety monitoring of the service.

Inadequate

Is the service safe?

Our findings

At the last inspection this service was rated inadequate and placed into special measures. We had identified that the provider was not meeting the regulations and people were not safe. The concerns had been identified during inspections in March 2017 and again in November 2017. At this inspection we found that sufficient improvements had not been made and people remained at high risk of poor care. We found continued issues with the oversight of risk, the management of medicines and staffing.

Following the last inspection we took urgent action and placed a number of conditions on the services registration with the aim of driving improvement and reducing the risk of people being exposed to harm. However at this inspection we found that they were not fully complying with all of these conditions.

Practices at the service did not protect people and there was a lack of understanding of the causes of behaviour and how people's distress should be managed. We heard an individual calling out and staff told us that they were held by, "two or three staff" to deliver personal care as the individual, "lashes out." This was not referred to in their care plan, there was no guidance for staff to follow to reduce the individual's distress and engage positively with them. A referral had not been made to the dementia support services for specialist advice. Staff were not trained in, "holding" or restraint and consideration had not been given to what was in this individuals best interests. Following the inspection we raised our concerns about this individual's welfare with the safeguarding team. The registered manager told us that they would seek an urgent review of their needs.

There were some risk assessments in place but these did not adequately address risk and staff were not always aware of or follow the management plan. At the last inspection we identified that the service was supporting a number of people who were at risk of choking and we required them to seek advice from the SALT team. At this inspection we were told by staff that an individual needed a liquidised diet as they struggled to eat foot with, 'bits in' due to risk of choking, however we observed that another member of staff served the individual fruit cake which placed them at risk of choking. Advice had not been obtained as required from the SALT team.

Another person had been assessed as requiring a pureed diet. The SALT team had provided the service with specific guidance to follow to ensure the food was of the correct consistency to reduce the likelihood of choking. We observed that the individual was served a meal which did not correspond with the guidance given which placed them at risk. Staff were not clear about what was required or the level of risk. Following the inspection we raised our concerns about this individual's welfare with the local authority safeguarding team.

The support to people with catheters placed them at risk of urinary tract infections. One of the people whose care we looked at had a catheter and there was no information in their care plan about the size or how often the catheter should be changed. We saw that the catheter bag had been fitted incorrectly by a member of staff and had been placed over the individual's knee. This caused the bag to kink increasing the risk of back flow of urine, and a urinary tract infection. Fluid input and output were not being consistently

monitored and we had concerns about the colour of this individual's urine and asked the member of staff on duty to seek immediate advice.

People were at risk of falling from hoist slings because peoples moving and handling needs were not assessed and staff were not always clear how the equipment should be used. Individuals had not all been assessed for a specific size of sling suitable for their needs. One individual had been discharged from hospital the week prior to the inspection. Their needs had changed since their previous stay at the service but we could not see that a reassessment had been undertaken, their care plan updated and appropriate equipment obtained. We observed a member of staff attempting to use another individuals sling to assist this person to move between the chair and their bed. This was an open access sling and had not been assessed for this individual to use. The staff member subsequently obtained a stand aid sling which was unsuitable for the equipment in place. The member of staff did not demonstrate competency or an understanding of the risks associated with moving and handling. We intervened to protect the person and asked the registered manager to take urgent steps to address this issue and provide the equipment the individual needed.

This is a continued Breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found some parts of the environment presented risks to people and there was a lack of environmental risk assessments in place to guide staff on the steps they needed to take to protect people and reduce the likelihood of harm. We placed a condition on the registered provider requiring them to seek professional advice on areas of health and safety. At this inspection we found that some improvements had been made, there were window restrictors in place and the heating in the bathroom had been repaired. However other areas remained outstanding and had not been addressed in a timely manner. For example at the last inspection we had concerns about the arrangements in place for the prevention and detection of legionella and asked the registered manager to urgently address them. We found that this had not yet been resolved, and water samples had only recently been sent off for analysis.

At the last inspection we identified issues with the laundry which was unlocked and contained a number of chemicals. At this inspection we found the door again unlocked and a number of chemicals in the sink. The service supported a number of people with dementia and these items would have presented a hazard to people if consumed.

The ceiling in the laundry had been damaged which meant that the fire alarm was not in use and there was a sign on the light switch stating not to use. A risk assessment had been completed some weeks previously which concluded that they would wait for the fire officer's visit. This was unsatisfactory response to the level of risk. Other areas of the service remained in need of refurbishment and re-decoration and there continued to be a lack of routine maintenance. For example, the windows at the rear of the service remained in need of painting as bare wood was exposed and walls in people's rooms were scuffed.

At the last inspection, we found issues with cleanliness, at this inspection we found continued issues. We found some of the bathrooms did not have soap to enable staff and people using the service to wash their hands. We found a strong smell of urine in one room, stained bed linen and a soiled mattress in another. Staff told us that there had been issues with cockroaches and we saw a trap in place.

This is a continued Breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Concerns with the management of medicines has been identified at the last two inspections and as a result we placed a condition on the providers registration requiring them to ensure that there was at least one member of staff on shift at all times who was trained and competent to ensure the safe administration of medicines. Prior to the inspection the local authority informed us that they had concerns about the management of medicines and had raised a safeguarding alert about the practices that they observed. At this inspection we found that medicines continued not to be managed safely and the service was not complying with the condition which had been placed on their registration. Staff were not following guidance and had dispensed medicines to administer later. This is unsafe practice and placed people at risk of receiving the wrong medicines. We checked a sample of medicines and found that the amounts of medicines did not tally with the records. We saw that one person had not received their Alendronic acid the previous day as prescribed. We observed that staff were not following the guidance and were planning to administer this medicine with other tablets after the individual had eaten. We intervened as this practice placed them at a higher risk of complications associated with alendronic acid such as irritation of the oesophagus or dyspepsia, causing them unnecessary pain and discomfort.

This is a Breach of Regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspections on 2 March 2017 and on 28 November 2017 we found shortfalls in staffing numbers and competency which had a direct impact on people's safety and the care and support being provided. Sufficient numbers of competent staff were not always available to meet the complex needs of the service users living in the service both during the day and at night. We placed conditions on the registered provider's registration requiring them to ensure that competent staff were available and review training across the service.

At the inspection on 21 February 2018 we found continued issues with the competency and availability of staff which meant that people continued to be at risk of poor care. On arrival at 8.10am six people were sitting in the lounge of which five were asleep. Two people looked very uncomfortable and their heads were leaning forward unsupported. Staff told us that they were assisted to get up and have breakfast by the waking night member of staff. Most people spent the rest of the morning asleep and we could not see that getting up early was in line with their preferences or needs. A member of staff told us that later in the day that one person fell from the chair onto the floor. We saw that there were periods in the waking day when there were only two members of staff on the premises which meant that areas of the service including the communal areas were unsupervised when the two staff were supporting other people in bed.

We saw that the service supports a number of people who have been identified as being at risk of pressure ulcers and requiring regular repositioning during the night. There was only one member of waking night staff and a sleep in member of staff and it was unclear how this was undertaken safely throughout the night. We looked that repositioning records for one person who had been identified at risk and saw that there were significant gaps. Concerns were raised with us about the staffing arrangements at night and we raised these under the safeguarding procedures with the local authority.

Staff did not have sufficient levels of training or expertise to meet the needs of the people living in the service. We observed a member of staff checking a person's catheter by pulling at the leg of their trousers. The person was asleep and they showed no concern for their wellbeing, pain or comfort. They demonstrated a lack of understanding of catheter care or dignity. We identified concerns about staff understanding of moving and handling and knowledge of serving food to people who require specialist diets.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18(1) Staffing.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in November 2017 we found the service was not well led and rated the service as inadequate. As a result the service was placed in special measures. The provider was also the registered manager. They also managed another nearby residential care home for older people, which they also owned. This service was at the time of the inspection also rated as inadequate.

Following our last inspection the registered provider provided us with assurances that they were addressing the issues that we had identified and told us they had appointed a management consultant to support them. However we were subsequently informed that the provider had struggled to retain the services of the consultant, and two separate consultants who had started work at the service resigned shortly after starting. The registered manager told us that they were working with another management consultant and the local authority quality team were also offering advice and guidance. Following the last inspection we placed urgent conditions on the registered provider's registration as we were concerned that people had been exposed to harm. At this inspection we found that there had been improvements in some areas, for example in the organisation of staffing roster and provision of foodstuffs. Staff now received their rota in advance and there were records to show that handovers, although brief were undertaken between shifts to improve communication amongst staff. There was a menu in place and fresh vegetables available for staff to prepare. However sufficient progress had not been made in other key areas which meant that people remained at risk of harm. There remained widespread shortfalls in the care provided which demonstrated a lack of effective managerial oversight.

We found sufficient controls were not in place to mitigate the risks to people's health, welfare and safety. These issues are outlined in the SAFE section of this report, but in summary staff failed to demonstrate that they were knowledgeable and competent in areas such as moving and handling, medicines, management of distressed behaviours, catheter care and specialist diets. The care provided was not person centred and always reflective of people's needs. Staff told us that they did not have time to provide activities and people spent long periods of time disengaged and asleep. Staff did not receive the direction and leadership they needed to support people with dementia and ensure that they received care which promoted their wellbeing and was not restrictive.

Some staff were kind and caring and were visibly upset about the shortfalls in the care that was being provided. They expressed concerns about the training and competencies of some of the staff who did not always understand the English language and the requirements of the role. However we also observed that some staff did not understand some practices as poor and lacked empathy and understanding of their responsibilities to safeguard people. Staff had not all received the training they needed or were being managed in an effective way to ensure that people were safe.

Staff morale was low and staff told us that did not feel appreciated. They told us that they were under pressure to work additional hours. They raised concerns about the leadership at the service and told us that it was not sufficiently proactive and did not always address issues, which discouraged them from reporting concerns.

The registered provider had undertaken some audits but these had not identified all the areas of concern that we found. For example they had not identified that the laundry room was not being securely locked, the gaps in record keeping, poor care practice and medication issues.

These shortfalls are a continuing Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider told us of their intention to close Bellevue to enable them to concentrate their attention on the other residential care home which they owned. Some but not all staff were aware of this and expressed concerns to us about how the process of closing the service was being managed. They told us that the registered manager was telling some but not other staff and did not think it had been managed in an open way. We spoke to the registered manager about this and they told us that they planned to meet with all staff, people living in the service and their carers to ensure that they were fully informed of developments.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to mitigate the risks to people using the service Medicines were not being managed in a proper and safe way

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment were not always properly maintained

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems to monitor and improve the quality and safety of service were not working effectively

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably competent and skilled staff were not always available to support people