Belle Vue Healthcare Limited

Bellevue Healthcare Limited

Inspection report

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13 October 2016
11 November 2016

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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

We inspected Bellevue Healthcare Limited on 13 October and 11 November 2016. This was an unannounced inspection which meant staff and registered provider on each occasion did not know we would be visiting.

At the last comprehensive inspection completed on 21 March, 5 and 18 April 2016 we judged the home to be rated as inadequate and found multiple breaches of our regulations. The service had been placed into serious concerns protocol with the local authority since March 2016. The professionals involved in the serious concerns protocol had significant concerns about the registered provider's ability to provide safe care and support to people. An embargo was put in place which meant that nobody new could move into the service.

Not having a registered manager is a breach of the registered provider's conditions of registration. Following the inspection completed in April 2016 we issued a fixed penalty notice for this matter and the registered provider paid the £4000 fine in order to deal with this breach.

We carried out a further inspection on 12 May 2016 because of growing concerns about people's safety. We found that although the risks had not increased they still remained around ensuring people received safe care and treatment. People were not placed at any greater risks from staff failing to administer medication in line with their prescriptions and were receiving adequate food and fluid. However, when people lost weight, we found staff were still failing to ensure referrals to dieticians were consistently made.

We completed a further inspection on 5 and 15 September 2016 because concerns were still being identified and we wanted to make sure people were safe living at the service. We also wanted to make sure the registered provider was taking action to address the concerns which we had identified during the last two inspections completed in April 2016 and May 2016.

We identified that four people were grossly underweight and all had Body Mass Indicators (BMI) of below 18. This shows that people are at risk of being malnourished and developing a compromised immune function; respiratory disease; digestive diseases; cancer and osteoporosis. One person had a BMI of 12, which placed them at very high risk of developing life threatening health conditions. Despite referring people to dieticians in July 2016 the staff had not recognised that people continued to lose weight and that their BMI were extremely low so had not got back in touch with the dieticians.

Following our visit on the 5 September 2016 we wrote to the registered provider to make them aware of our serious concerns about people's welfare and asked them to take immediate action to ensure people's health was not compromised. On 15 September we visited to check that the action the registered provider had said would be taken had occurred. We found that they had compiled a list of people's current weight and people who had wounds. They had contacted GPs and dieticians for all people who were found to have compromised weights and with wounds.

However we also found that one of the registered provider's directors, who is a retired GP and without a license to practice had been completing and signing 'Do not attempt cardio-pulmonary resuscitation (DNACPR), as senior consultant. This is a breach of the Medical Act 1983. We found that some people's DNACPR certificate stated 'general frailty' rather than a specific clinical condition, which does not comply with the General Medical Council (GMC) code of practice. We issued a Notice of Decision under our urgent powers requiring that the provider review the fitness of this director and investigate the completion of the DNACPRs and the role of the clinical lead. Subsequently the director stepped down from the company.

Bellevue Healthcare Limited is registered to provide care and support to 102 people. There were three units at the service which provided care and support to people living with a dementia, people who required nursing care and young adults living with a physical disability.

A registered manager came into place in November 2016. 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.

We commenced this inspection as the local authority reported they were observing significant improvements in the operation of the home.

In October 2016 we did initially find evidence that action had been taken to refer people health professionals for nutrition, dehydration and pressures sores however care plans had not been developed/updated. When we visited in November 2016 to continue to review the delivery of care we found that minimal improvements noted in October 2016 had not been sustained. The registered provider continued to fail on multiple levels to ensure people were receiving safe and effective care and treatment. We found steps had not been taken to ensure service users received adequate fluids, were not unintentionally losing weight, identified wounds were managed appropriately and that service users received safe care and treatment.

We found that one person had lost 3kg in weight between 3 October 2016 and 9 November 2016. Their nutrition care records stated that any loss of 3kg should be reported and action taken. We noted that the care staff had raised this with the nurse on duty. However, the nurse failed to act and this had not been picked up via the registered provider's systems for overseeing the performance of the home or within their recently introduced weight monitoring tool.

We saw that since the introduction of a weight monitoring tool in October 2016 staff had not recalculated the service user's BMI despite weight change. Also staff on the residential unit had not recorded the service users' height on this tool so it was unclear how staff had worked out the individuals BMI in the first instance. For instance one person's weight from October 2016 had fluctuated between 50. 3 kg and 53.4kg but their BMI had always been recorded at 18.1. This person was at risk of malnutrition with a BMI of 18 and the variation of weight could have increased that risk. We found that no checks had been made to ensure staff accurately completed the tool. Thus, the senior staff were unaware of the issue.

We saw on the nursing unit the staff had recorded service users' height but found this recording could not be relied upon. In one person's file the dietician had recorded their height as 1.62m but staff at Bellevue Healthcare had recorded their height at 1.58m. This discrepancy had led to the true BMI being masked and could lead to staff to failing to identify if someone's weight dropped into ranges which were indicators of risk and malnutrition.

One person's who receives food and fluid via Percutaneous endoscopic gastrostomy (PEG) records had not been updated following a dietician letter dated 16 September 2016 which stated they must receive 700mls of fluids each day in addition to food and flushes. We discussed this with the nurse who told us they were unaware of the change to the regime. The nurse informed us that the person required 500mls of fluid per day. However, inspectors noted that they had not even been receiving the 500ml of fluids per day. We reported this matter to the local safeguarding team.

We also found that one person continued to refused food and fluid. Within their care records we found contradictory information about their capacity to make these decisions. In one care plan it was recorded that the person lacked capacity to make decisions. However, in their capacity care-plan it indicated they had full capacity and every evaluation of this care plan stated that the person had full capacity to make all decisions. This was despite noting in the actions section of the plan that a Deprivation of Liberty Safeguards (DoLS) authorisation had been sought; an assessment was needed to determine if they had the capacity to decide to refuse food and fluid and a multidisciplinary team meeting needed to be held with the GP to determine if best interest decision was needed to address their refusal of food and fluid. We found the nurse evaluating the capacity care plan had failed to understand the requirements of the Mental Capacity Act 2005 and the registered provider's oversight of this had failed to identify this gap.

We also saw that one person had been assessed in 2014 as requiring a soft diet and thickened fluid because they had an impaired gag reflex and was therefore at high risk of choking. In August 2016 the Speech and Language Therapist (SALT) team had noted that the person continued to have episodes of choking and chest infections but still refused to follow their advice so took a normal diet. The SALT team referenced that in 2014 a capacity assessment had been completed. The capacity assessment completed at that time showed that the individual was aware that eating a normal diet could be fatal either because of choking or aspirational pneumonia.

Due to the continued high level risk being posed by the refusal to eat a soft diet and take thickened fluids in August 2016 the SALT team recommended the staff revisit the person's capacity to make this decision. However, no one from the service had completed a capacity assessment and either ensured a best interest decision was made around making sure they followed the SALT team recommendation or signed a consent form stating they accepted the risk that this decision could be fatal. The registered provider's oversight of this had failed to identify this gap.

We found that there was no evidence of alternatives offered when people had not eaten meals. Coffee was recorded as one person's evening meal. There were gaps in food and fluid balance records. Baseline fluid levels were not in place.

The registered provider visited the service each day and we observed them carrying out checks of the service, however they had not recorded any of their visits as part of quality assurance processes. This meant we could not see what checks were being carried out.

The service had introduces some audits. However these failed to pick up issues around medication balances being incorrect; gaps within the records relating to creams; care records being inaccurate or contradictory; the issues with PEG feeds and risks of dehydration or malnutrition.

Where actions for improvement had been identified action plans had been produced but there was no evidence of any action taken check these were plans were followed or the audit recompleted.

We found the provider was continuing to breach the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014 identified during inspection on 21 March, 5 and 18 April 2016. These breaches related to safe care and treatment, dignity, consent, person-centred care, nutrition, safeguarding, staffing and governance. The overall rating for the service was 'Inadequate' and this will remain. The service will remain in 'Special measures'. Services in special measures will be kept under review. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

We have judged the risks posed to be major and are taking action in line with our enforcement policy.

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

The service was not safe.

Staff failed to recognise and report some allegations of abuse when needed.

Risk assessments were not always in place where needed. Care plans were not always personalised and did not always accurately reflect people's health needs and risks.

People's health, safety and wellbeing continued to be at risk, especially in relation to dehydration, malnutrition and pressure ulcers.

Is the service well-led?

Inadequate

The service was not well led.

The systems in place at the service were failing to appropriately recognise and respond to people who were at risk of choking, malnutrition and dehydration.

The systems for overseeing staff practice did not identify that staff failed to understand the requirements of the Mental Capacity Act and the procedures for depriving a person of their liberty. There was also no evidence of 'Best interests' decision making.

Despite new audits being put in place care plans for nutrition and hydration remained inaccurate and did not reflect people's individual needs. Food and fluid balance records were incomplete and did not show if people were receiving adequate intake.

Quality assurance processes were not regularly carried out and had not highlighted the concerns we found during this inspection to keep people safe.

Bellevue Healthcare Limited

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.

Three adult social care inspectors completed the inspection on 13 October 2016 and on 11 November 2016.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We reviewed feedback from the local authority commissioning team for the service, from the serious concerns protocol forum (which we have regularly attended) and from the clinical commissioning group (CCG).

During the inspection we spoke with eight people who used the service. We also spoke with the registered provider, registered manager, clinical lead, five nurses and eight care staff.

We spent time with people in the communal areas and observed how staff interacted and supported people. We looked at 14 care records, medicine administration records, weight monitoring records and pressure care records. We also reviewed staff rotas, staff recruitment records, safeguarding records and quality assurance records.

We looked around the service and went into some people's bedrooms and bathrooms (with their permission) and spent time in communal areas.

Inadequate

Is the service safe?

Our findings

On 5 September 2016 we identified that four people were grossly underweight and all had Body Mass Indicators (BMI) of below 18. This showed that people were at risk of being malnourished and developing a compromised immune function, respiratory disease, digestive diseases, cancer and osteoporosis. One person had a BMI of 12, which placed them at very high risk of developing life threatening health conditions. Despite referring people to dieticians in July 2016, staff had failed to recognise that people had continued to lose weight and that their BMI's were extremely low. This meant they had not taken action to get back in touch with the dieticians involved in these people's care.

Where safeguarding alerts established that malnutrition or dehydration had occurred there was no evidence to show that the service had taken action to reduce the risk of the incidents from re-occurring. We also identified that when people's nutritional supplements had not been received in a timely fashion; staff had not contacted the GP or dietician to request they were delivered. This had led to people not receiving the required supplements for over a month. In the interim these people continued to lose weight.

We found that there was no evidence of alternatives offered when people had not eaten meals. Coffee was recorded as one person's evening meal. Food and fluid balance charts had not always been completed. Records showed that people consumed less fluid than was specified in their care plans; staff had not taken action when people's fluid intake was low. There was no evidence to suggest that people were offered snacks outside of meal times or that people at increased risk of malnutrition were offered nutritional supplements.

In October 2016 we did initially find evidence that action had been taken to refer people to health professionals for nutrition, dehydration and pressures sores however care plans had not been developed or updated. When we visited in November 2016 to continue to review the delivery of care we found that minimal improvements noted in October 2016 had not been sustained. The registered provider continued to fail on multiple levels to ensure people were receiving safe and effective care and treatment. We found steps had not been taken to ensure service users received adequate fluids, were not unintentionally losing weight, identified wounds were managed appropriately and that service users received safe care and treatment.

We found that one person had lost 3kg in weight between 3 October 2016 and 9 November 2016. Their nutrition care records stated that any loss of 3kg should be reported and action taken. We noted that the care staff had raised this with the nurse on duty. However, the nurse failed to act and this had not been picked up via the registered provider's systems for overseeing the performance of the home or within their recently introduced weight monitoring tool. We raised this during inspection with the registered manager and immediate action was taken in relation to the weight loss and disciplinary procedure commenced. We reported this matter to the local safeguarding team.

One person had lost 5.6kg between 25 September 2016 and 12 October 2016. The care records did not show what action had been taken following this 5.6kg weight loss. Staff told us that this person had been in hospital but were not aware of any action taken by the service since their return from hospital. The care

records of another person showed they had lost 20.3kg between 4 September 2016 and 2 October 2016 and then gained 22.6kg between 2 October 2016 and 5 October 2016. In each of these cases, there was no evidence to show what action staff had taken or whether the accuracy of chair scales had been checked. There was no evidence to show that staff had reported these findings. Weight monitoring tools in place had failed to identify these discrepancies.

One person received their nutrition and hydration via a Percutaneous endoscopic gastrostomy (PEG) tube. These PEG regime records had not been updated following a dietician letter dated 16 September 2016 which stated they must receive 700mls of fluids each day in addition to food and flushes of fluids. We also found that the nutritional care plan in place did not match the PEG regime in place on the day of inspection or the dietician letter. We discussed this with the nurse who told us they were unaware of the change to the regime. The nurse informed us that the person required 500mls of fluid per day. However, inspectors noted that they had not even been receiving the 500ml of fluids per day. We reported this matter to the local safeguarding team.

We also found that one person continued to refused food and fluid. Within their care records we found contradictory information about their capacity to make these unwise decisions. In one care plan it was recorded that the person lacked capacity to make decisions. However in their capacity care-plan it indicated they had full capacity and every evaluation of this care plan stated that the person had full capacity to make all decisions. This was despite noting in the actions section of the plan that a Deprivation of Liberty Safeguards (DoLS) authorisation had been sought; an assessment was needed to determine if the person had the capacity to decide to refuse food and fluid and a multidisciplinary team meeting needed to be held with the GP to determine if best interest decision was needed to address their refusal of food and fluid. We found the nurse evaluating the capacity care had failed to understand the requirements of the Mental Capacity Act 2005 and the registered provider's oversight of this had failed to identify this gap.

We also saw that one person had been assessed in 2014 as requiring a soft diet and thickened fluid because they had an impaired gag reflex and was therefore at high risk of choking. In August 2016 the Speech and Language Therapist (SALT) team had noted that the person continued to have episodes of choking and chest infections but still refused to follow their advice so took a normal diet. The SALT team referenced in 2014 that a capacity assessment had been completed. The capacity assessment completed at that time showed that the individual was aware that eating a normal diet could be fatal either because of choking or aspirational pneumonia. Due to the continued high level risk being posed by the refusal to eat a soft diet and take thickened fluids in August 2016 the SALT team recommended the staff revisit the person's capacity to make this decision. However, no one from the service had completed a capacity assessment and either ensured a best interest decision was made around making sure they followed the SALT team recommendation or signed a consent form stating they accepted the risk that this decision could be fatal. The registered provider's oversight of this had failed to identify this gap.

We found that staff were not identifying the development of pressure ulcers clearly. This meant care plans had not been produced to detail how these were being treated or the action they needed to take if the pressure ulcer changed or became infected. Staff had not been accurately identifying and recording when people had pressure ulcers. Referrals had not been carried out in a timely manner. Two hourly checks of people who required positional changes to prevent pressure ulcers had been completed to show people had been checked but did not always show if a turn had been carried out.

External support had been put in place to improve the management of medicines at the service. The service had started to make improvements to the management of medicines. However we found that further improvements were required. We found that albeit the clinical lead completed audits they merely looked at

the MARs and did not complete a stock balance check. When we completed this type of check we found discrepancies in the medication stock. Topical cream records were incomplete and did not show if they were applied as prescribed.

On our arrival at the service of both days of inspection, the nurse in charge of the service could not tell us how many people were using the service. Nurses on duty on each unit could only give this information once they had checked their records. This was of concern to us because this meant staff would not be able to give the information needed during an emergency.

This was a continued breach of regulation 11 (Need for Consent), regulation12 (Safe care and treatment) and 14 (Meeting nutritional needs) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

During our comprehensive inspection of the service on 21 March, 5 and 18 April 2016, we identified that care plans were not person-centred and lacked the detail needed to provide care and support to people safely and according to their wishes, needs and preferences. Care plans were not always reviewed within the timescales set by the registered provider. People had the same care plans in place regardless of whether they were needed. Some people did not have the care plans in place which were specific to their individual needs.

At the inspection in September 2016 we found new core care plans had been introduced. This meant that each person had the same care plans in place whether or not a specific need had been identified. For example, there were care plans in place for breathing and consciousness where people did not have any health needs. Care plans were difficult to follow at times, were not personalised and contained similar actions for each area of care for everyone looked at. Although care plans contained descriptions of what to do in relation to each care plan, they contained limited information about each person's individual needs. Some care plans were inaccurate and minimised people's needs. There were also gaps in care plan reviews during June and July 2016. Where people had short term conditions, such as infections no care plans had been put in place.

In October and November 2016 we found that the care plans remained difficult to follow and again some care plans were inaccurate. We found that some people's care records failed to identify the significant risks being posed. A care plan audit for one person highlighted that a risk of choking and complications to nutrition resulting from their health condition needed to be updated in the person's care plan. Recommendations following contact with the SALT team and information about how the person could communicate with people also needed to be included into the person's care plans. However, these had not been completed.

We found that people's fluid balance and dietary intake records had been stored in a jumbled manner in broken lever arch folders at the bottom of filing cabinets. We saw that for one person jumbled information related to October 2016, which showed staff were predominantly offering 200mls of fluid between 10 and 14 times but occasionally only twice per day. The person often refused the fluids although they needed to drink 1780mls according to the guidelines the home was following. The majority of recordings showed that from 14 October 2016 they had taken 600 to 750mls and on two occasions only drank 50mls of fluids. From discussions with the staff and the review of records we found that the systems in place for monitoring their food and fluid intake were ineffective and could find no evidence that action had been taken to contact the GP or other healthcare professionals when the individual had restricted their fluid.

This is a continued breach of regulation 9 (Person-centred care) and regulation 12 (Safe care and treatment)

of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

We looked at recruitment records for three newly recruited staff members. We could see that appropriate checks ad been carried out, for example two checked references had been received and a Disclosure and Barring services (DBS) check had been obtained prior to employment starting. However, we looked at the recruitment documents for a newly appointed unit manager. We could see that an application had been completed but this only contained employment details from April 2016 and did not provide sufficient details. This person had been interviewed the day before the inspection and was offered the position but we could not see any interview questions. A contract of employment had been signed by this person. The registered provider told us this person had only just been appointed and further recruitment checks would be made before employment commenced. This meant a candidate had been offered a position at the service without appropriate recruitment checks carried out to assess the suitability of the candidate.

This is a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

During our inspection in October 2016, we found that people's dignity continued to be compromised. We passed one person's bedroom and found a dish on the floor besides their bed which contained urine. We intervened because the person was about to step into this dish as they got up from their bed.

This was a continued breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Following our visit on the 11 November 2016 we wrote to the registered provider to make them aware of our serious concerns about people's welfare and asked them to take immediate action to ensure people's health was not compromised.

Inadequate

Is the service well-led?

Our findings

At the last comprehensive inspection completed on 21 March, 5 and 18 April 2016 we judged the home to be rated as inadequate and found multiple breaches of our regulations. The service had been placed into serious concerns protocol with the local authority since March 2016. The professionals involved in the serious concerns protocol had significant concerns about the registered provider's ability to provide safe care and support to people. An embargo was put in place which meant that nobody new could move into the service.

Not having a registered manager is a breach of the registered provider's conditions of registration. Following the inspection completed in April 2016 we issued a fixed penalty notice for this matter and the registered provider paid the £4000 fine in order to deal with this breach.

A registered manager was in now in place. Staff told us they had confidence in the registered manager and felt they were making improvements at the service. One staff member told us, "Things are improving. [Registered manager] is very approachable. The registered manager was open and honest during inspection. They told us change had been difficult to achieve and a change to the culture at the service was needed as well the staff team working together. We could see they had started to put systems in place; however they did not always achieve the outcome needed because at times staff failed to report concerns or failed to take the action needed. Staff responsible for carrying out quality assurance checks and completing care records failed to take the action needed when concerns were evident from these records. This meant the registered manager had not always been able to take action because they had not been made aware.

We carried out a further inspection on 12 May 2016 because of growing concerns about people's safety. We found that although the risks had not increased they still remained around ensuring people received safe care and treatment. People were not placed at any greater risks from staff failing to administer medication in line with their prescriptions and were receiving adequate food and fluid. However, when people lost weight, we found staff were still failing to ensure referrals to dieticians were consistently made.

We completed a further inspection on 5 and 15 September 2016 because concerns were still being identified and we wanted to make sure people were safe living at the service. We also wanted to make sure the registered provider was taking action to address the concerns which we had identified during the last two inspections completed in April 2016 and May 2016.

We identified that four people were grossly underweight and all had Body Mass Indicators (BMI) of below 18. This shows that people are at risk of being malnourished and developing a compromised immune function, respiratory disease, digestive diseases, cancer and osteoporosis. One person had a BMI of 12, which placed them at very high risk of developing life threatening health conditions. Despite referring people to dieticians in July 2016 the staff had not recognised that people continued to lose weight and that their BMI were extremely low so had not got back in touch with the dieticians.

Following our visit on the 5 September 2016 we wrote to the registered provider to make them aware of our

serious concerns about people's welfare and asked them to take immediate action to ensure people's health was not compromised. On 15 September we visited to check that the action the registered provider had said would be taken had occurred. We found that they had compiled a list of people's current weight and people who had wounds. They had contacted GPs and dieticians for all people who were found to have compromised weights and with pressure ulcers.

We also found that one of the registered provider's directors, who is a retired GP and without a license to practice had been completing and signing 'Do not attempt cardio-pulmonary resuscitation (DNACPR), as senior consultant. This is a breach of the Medical Act 1983. We found that some people's DNACPR certificate stated 'general frailty' rather than a specific clinical condition, which does not following General Medical Council (GMC) code of practice. We issued a Notice of Decision under our urgent powers requiring that the registered provider review the fitness of this director and investigate the completion of the DNACPRs and the role of the clinical lead. Subsequently the director stepped down from the company. Following our September, October and November inspections, we raised concerns about the competency of the clinical lead. We asked the registered provider to review the competency of the clinical lead and demonstrate their fitness to carry out their role. Following inspection in November, the registered provider informed us that the clinical lead is no longer working at the service and the service had made a referral to the Nursing Medical Council (NMC).

At the inspection in October and November 2016 we found that when people lost weight staff were still failing to ensure referrals to dieticians were consistently made. During this inspection, we identified that the service was still failing to appropriately recognise and respond to people who were at risk of malnutrition and dehydration. Safeguarding alerts had still not been raised by staff for people at risk of malnutrition and dehydration. The registered manager had however raised an alert following a nurse not taking action to contact healthcare professionals when a person had developed a pressure ulcer. But failed to take action in a prompt and timely manner to address the particular nurse's persistent poor performance and failure to adhere to the home procedures. Following the concerns raised during the inspection, the registered manager started the disciplinary process procedure and a referral to the NMC was made.

Systems were ineffective for ensuring people's nutritional needs were not compromised. For instance we saw that since the introduction of weight monitoring tool in October 2016, staff had not recalculated the service user's BMI despite weight change. On the residential unit staff had not recorded the service user's' height on this tool so it was unclear how staff had worked out the individuals BMI in the first instance. For instance one person's weight from October 2016 had fluctuated between 50. 3 kg and 53.4kg but their BMI had always been recorded at 18.1. This person was at risk of malnutrition with a BMI of 18 and the variation of weight could have increased that risk. We found that no checks had been made to ensure staff accurately completed the tool. Thus the senior staff were unaware of the issue.

We saw on the nursing unit the staff had recorded service users' height but found this recording could not be relied upon. In one person's file the dietician had recorded their height as 1.62m but staff at Bellevue Healthcare had recorded their height at 1.58m. This discrepancy had led to the true BMI being masked and could lead to staff to failing to identify if someone's weight dropped into ranges, which were indicators of risk and malnutrition.

We found that despite us making the registered provider aware of concerns around nutrition and hydration, there was no evidence of alternatives offered when people had not eaten meals. We noted that 'Coffee' was recorded as one person's evening meal. Staff continued to fail to record what people were offered and still recorded that individuals had 'coffee' as a meal. This meant that we did not know if this person had received adequate nutrition on these days.

Again in September we had made the registered provider aware that when we looked at people's fluid balance records, we could see that people were not meeting the targets set for their daily fluid intake. For instance we looked at one person's fluid balance records between 24 and 27 August 2016 and 1 and 4 September 2016 and found their daily fluids totalled between 100 and 1000 millilitres of fluid for each day. We could see this did not meet their guidance contained within their care plan. There was no evidence to show what action staff had taken on each of these days.

In October and November 2016 we found that this inaccurate recording continued and staff failed to contact other healthcare professionals when people were restricting their fluid intake or not consuming adequate fluids. For instance in October 2016 we found that one person only drank 600 to 750mls but could find no evidence to show that action had been taken to contact the GP or other healthcare professionals when they had restricted their fluid to well below the recommended volume of 1780 millilitres.

We found that some concerns had been raised following a meeting for people and their relatives on 12 September 2016 relating to training, staffing and staff conduct. No action plan had been carried out following this and we could not see what action had been taken to address this. Audits had been carried out at the service during October and November 2016, however not all had been completed. In some of the audits looked at, we could see that areas for improvement had been identified and time frames given. These improvements included updating information in care plans and completing overdue risk assessments, however no action had been taken. In the audit of one person's care plan audit, the audit stated that care plans for nutrition including a nutritional risk assessment needed to be improved within 48 hours because of the concerns identified.

Inspectors found that these discrepancies had not been identified by the clinical lead who was responsible for assessing and monitoring the performance of the home. Staff continued to make the same errors as identified at inspections in April, May and September 2016.

It was concerning that although we had raised serious concerns in September 2016 that people may be exposed to the risk of harm, or serious risk to their life, health and wellbeing and had been given robust assurances that risks would be reduced. In November 2016 we continued to find they had failed to mitigate the serious risks being posed to people who used the service. We found that the registered provider continued to fail to ensure systems and processes were in place to assess, monitor and improve the quality of the home. Also they continued to fail to ensure the oversight of the home mitigated identified risks or to ensure staff were competent to undertake the tasks they were assigned.

This is a breach of regulation 12 (Safe care and treatment) and, 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to ensure their governance systems effectively assessed, monitored the home and mitigated risks posed to people who used the service. Regulation 17 (1)

The enforcement action we took:

We took urgent action to require the registered provider reviewed the competency of the staff employed at the home and managed the risks posed to people who used the service.