Harbour Healthcare 1 Ltd

Belle Vue Care Home

Inspection report

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Date of inspection visit:
20 March 2018
21 March 2018
11 April 2018
12 April 2018

Date of publication:
25 May 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 20, 21 March and 11, 12 April 2018 and the first day was unannounced. This was the first inspection since the service was taken over by Harbour Healthcare 1 Ltd in November 2017.

Belle Vue is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Belle Vue accommodates 49 people in one adapted building, over two floors and is split in to a ground floor nursing unit and first floor dementia care unit. At the time of our inspection there were 32 people living at the home. The home supported older people, some with physical disabilities and long term medical conditions. Some people at the home were living with dementia.

There was no registered manager in post at the time of the inspection. We were supported on the first two days of the inspection by the interim manager and the newly recruited manager on the last two days of the inspection. 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.

People told us they felt safe living at Belle Vue. One person said, "I certainly feel as though I am safe here." However, we did not find that all of the provider's processes ensured people's safety.

The provider's recruitment processes were not fully effective and some pre-employment checks were incomplete.

Some risks to people's safety and well-being were assessed and care plans guided staff on how to meet people's care needs and manage risks. However, risk assessments were not always in place to support staff to understand and support people with their health. Where risks had been identified, records did not always show that care had been delivered as it should. Records did not always demonstrate staff were maintaining effective oversight of some people's fluid intake to manage their risk of dehydration. People were not always being protected from the risk of malnutrition.

Since the provider took over the home in November 2017 they had been working hard to improve standards of care quality for people living at Belle Vue. They recognised they were still in the early stages of improving the quality of care were implementing improved care planning, monitoring and auditing processes. There were systems in place to monitor the quality of the service but these were not effective in identifying all areas where improvements were needed.

We received mixed views from people, relatives and staff about whether there were sufficient numbers of

staff deployed at Belle Vue. Some people told us they had to wait for care as staff were busy with other people. Staff told us they felt that some days were busier than others and an extra member of staff would be beneficial. They were aware people were having to wait for support, especially at mealtimes. We observed there were enough staff on the ground floor to meet people's needs. However, on the first floor dementia unit, we observed that some people had to wait for staff to help them. We made a recommendation that the provider reviews staffing levels within the home to ensure they meet the needs of the people.

People told us they would benefit from more activities at the home. One person commented, "There's not much to do here." Another said, "In some ways it's absolutely wonderful, all of the attention we get, but there is nothing going on in the afternoons. You need something to stimulate you." the home had a programme of activities and the management were looking at how they could enhance the provision of activities available to people.

People's medicines were managed and administered safely. There were suitable arrangements for ordering, receiving, storing and disposal of medicines. Where people had been prescribed medicines covertly (without their knowledge), staff had followed the correct procedures and consulted the pharmacy about the safest way to give the medicines. However, this had not always been documented. We made a recommendation about recording advice and discussions with regards to medicines in people's care records.

People told us they had enough to eat and drink. People were given choices of what to eat and staff checked with people if they had had enough to eat and drink. People's healthcare was monitored and health professionals involved where necessary.

People and their representatives were involved in the assessment and development of their care plans. Care plans identified people's needs and outlined how these needs would be met. However, care plans did not always include sufficient information about people's preferences to ensure they received person centred care at all times.

People were protected because staff understood their roles in safeguarding people from abuse. Staff had received training in safeguarding adults and information on how to raise safeguarding concerns was available. Staff received training specific to the needs of the people they supported. They told us they felt well supported in their role. Staff received regular one to one supervisions and appraisals with their manager where they could discuss their performance and their skills development.

People were treated with kindness and compassion and staff talked with them in a courteous and respectful manner. People knew the staff that supported them and it was clear from our observations that people, staff and relatives had formed positive relationships, resulting in a friendly and happy atmosphere within the home. People's rights to privacy and dignity were respected and they were supported to maintain relationships with people that were important to them.

People's legal rights were protected because staff followed the guidance of the MCA. Mental capacity assessments were used to assess people's ability to make specific decisions. Where people were unable to make decisions, best interest decisions were documented.

The provider ensured the safety of the premises. Regular checks were carried out on the health and safety of the building and maintenance works were actioned where improvements were identified. The environment at the home was clean and well maintained. People were protected from the spread of infection. The provider had plans in place for in the event of a fire and equipment in place to support staff. Staff were trained in fire safety and regular drills were conducted.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people health, safety, and well-being were not always being effective assessed, managed or mitigated.

Recruitment procedures were not always robust enough to ensure people were kept safe.

People received their medicines as prescribed. The systems in place for the management of medicines were safe and protected people who lived at the home.

People were protected from the risk of abuse, as staff understood the signs of abuse and how to report concerns.

There were sufficient numbers of skilled and experienced staff to meet people's needs.

Is the service effective?

Good

The service was effective.

People received care from staff that had the skills and knowledge to meet their needs.

Supervision systems provided staff with on-going support.

People's consent was sought before any care or support was provided. The requirements of the Mental Capacity Act 2005 (MCA) were being met.

People were supported to eat and drink enough to maintain a balanced diet.

Staff worked with external health and social care agencies to provide effective care.

People's needs were met by the adaptation, design and decoration of the premises.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

Staff displayed caring attitudes towards people and spoke about people with affection and respect.

People's privacy and dignity were respected.

People were involved in the planning of their care and were offered choices in how they wished their needs to be met.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's assessments and care plans did not always include sufficient information about individual preferences or guide staff about their preferred routines.

People were supported to take part in some activities they enjoyed. However, the provision of activities could be improved.

People had information on how to make complaints.

People were supported to plan and make choices about end of life care.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems to monitor the quality of the service were not yet embedded and as such were not being used effectively to ensure that people received a consistently good service.

There was an open, transparent culture and staff felt supported by the management team.

People were supported by staff who were happy in their work and felt valued.

The provider listened to, and acted on, feedback from people, their relatives and members of the staff team.

Belle Vue 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 was planned to check whether the provider was 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.

This inspection took place on 20 and 21 March 2018 and the first day was unannounced. Due to a infection at the home, we completed the inspection on 11 and 12 April 2018.

The inspection was carried out by one adult social care inspector on the first day and was joined by a second adult social care inspector and an expert-by-experience on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The lead inspector and second inspector returned on the third day. The inspection was completed by a pharmacy inspector on the fourth day.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the information in the PIR along with information we held about the home, which included incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law. We also contacted local council's Quality Assurance and Improvement Team and Safeguarding Adults Team to gain their feedback about the quality of the care and support provided to people.

We spent time in the communal areas of the home to observe how staff supported and responded to people. As some people at Belle Vue were living with dementia, we spent time carrying out a short observational framework for inspection (SOFI) observation. SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care.

As part of our inspection we spoke with the interim manager, new manager, regional manager for Harbour Healthcare, three registered nurses, one senior care staff, seven care staff, the chef, laundry assistant and a

cleaner. We spoke with six people and seven relatives.

We looked at a number of records relating to individual care and the running of the home. These included five people's care and support plans, four staff personal files and records relating to staff training, medication administration and the quality monitoring of the home.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Belle Vue. One person said, "I certainly feel as though I am safe here." Another person told us, "I've only been here for a few days and I haven't felt worried", their relative told us, "It's early days for me, but speaking as I find, I think it's wonderful here and I'm very happy to have my relative live here."

Staff knew people well. They had identified risks to their health and welfare and staff knew what to do to manage these risks. However, records in relation to risk management and delivery of care were incomplete.

Some risks to people's safety and well-being were assessed and care plans guided staff on how to meet people's care needs and manage risks. However, risk assessments were not always in place to support staff to understand and support people with their health. For example, one person was living with diabetes. There was no individual risk assessment in place to detail the risks associated with this condition for the person, such as low or high blood sugars or their impact on the person. There was no detailed care plan explaining how the person's blood sugar levels were being managed. This meant people may be at risk from a lack of a clear individual assessment of the risks associated with their health condition. Staff we spoke with knew how to manage this person's diabetes and care needs as they knew them well. However, records did not contain enough detailed information to assure the person's safe care if they were looked after by staff that did not know them well.

Where risks had been identified, records did not always show that care had been delivered as it should to mitigate the risks. For example, one person had a significant risk of developing pressure ulcers. Risk assessments had identified the need for regular repositioning. Their care plan said staff should 'assist [name] to relieve pressure from his pressure points. Position changes day and night.' The person's hourly checking and repositioning charts did not demonstrate the person had their position changed as documented in their care plan and risk assessment.

There was no indication the person had become sore and daily care notes recorded their skin was in good condition.

Records did not always demonstrate staff were maintaining effective oversight of some people's fluid intake to manage their risk of dehydration. Some people were having their fluid intake monitored. Fluid intake charts gave staff guidance on how much the person needed to drink each day and staff were recording the amount each person was drinking. However, where people had not achieved their recommended fluid intake target, care records did not demonstrate what action staff had taken as a result. This meant staff could not assure themselves people were having sufficient quantities to drink to maintain their health and reduce the risk of dehydration.

There was no indication that people had not received sufficient to drink as drinks were available and people were prompted by staff to drink throughout the inspection. People did not look dehydrated.

The provider had failed to ensure accurate, complete and contemporaneous records were in place for each service user. This was a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional needs had been assessed before they moved into the home and were kept under review. Where people required their food texture to be modified, such as pureed for people with swallowing difficulties, their care plans described this and we saw people being supported in line with this guidance. Where people had lost weight, referrals had been made to their GP or dieticians. Guidance and recommendations given by healthcare professionals had been included in people's care plans. However, it was not clear that recommendations had always been put into practice and guidance followed. For example, one person had been seen by the dietician because they had been losing weight. The dietician had recommended two high calorie milkshake drinks daily. Their fluid intake charts recorded the person had only been given two milkshakes in the six days following the dietician advice. Staff told us they were not aware of this and it was not identified on their handover sheet. This put the person at risk of malnutrition because recommendations from health professionals had not been followed.

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

Although not all risks had been documented appropriately, other risk assessments had been undertaken to enable people to retain independence and make their own choices, whilst minimising risk. Risk assessment tools were used to identify common risks such as those relating to falls, skin integrity and medicines. These included information about the action staff needed to take to minimise the possibility of harm occurring to people. For example, one person was at risk of choking and had been seen by the Speech and Language Team. Their care plan contained clear guidance about the consistency of their food and drink and how to support the person to eat safely, such as, to use a teaspoon when assisting them to eat. We saw this was how they were being supported during the inspection.

People were not always protected by safe recruitment practices. We looked at four staff records and found three records had incomplete employment histories. Employment history should be explored during recruitment. This meant the provider was not meeting the Schedule 3 requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014, to ensure that staff employed were safe to work at the home. This put people at risk of harm. Other employment checks, such as police checks and references, had taken place and were recorded in staff files.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People's medicines were managed and administered safely. There were suitable arrangements for ordering, receiving, storing and disposing of medicines, including medicines requiring extra security. Storage temperatures were monitored to make sure that medicines would be safe and effective. There were policies in place to guide staff on looking after medicines. These included policies so that people could look after their own medicines if it was safe for them to do this, although there were no residents doing this at the time of the inspection. The provider had a reporting system so that any errors or incidents could be followed up and actions taken to prevent them from happening again. There were weekly and monthly medicines audits being carried out. Actions were identified from these audits to help improve the service, and action plans were completed.

Registered nurses recorded medicines on medicines administration records (MARs). We checked 15 people's MARs and these showed that people were given their medicines correctly and in the way prescribed for

them. Registered nurses had recently been assessed for competency to make sure they gave medicines safely. The provider was arranging further medicines training.

Staff recorded the application of creams and other external preparations on separate charts stored in people's own rooms. These also provided guidance for care staff on how to apply them correctly. There were directions for medicines prescribed to be given 'when required' to guide staff on when it would be appropriate to give doses of these medicines.

We saw two people's records where they were receiving their medicines covertly (without their knowledge), as they lacked the capacity to consent. There were records of their mental capacity assessments, and 'best interests' decisions had been taken and recorded. We were told that the pharmacy had been consulted about the best way to give these medicines but their advice was not recorded in people's records.

We recommend that this advice and discussion be recorded in people's records, to show that the safest way to give these medicines had been considered.

We received mixed views from people, relatives and staff about whether there were sufficient numbers of staff deployed at Belle Vue. One person told us, "If you need to call for help using the button, they always come very quickly." However, some people told us they had to wait for care as staff were busy with other people. One said, "I can't move without the help of a carer and I have to call for help with the buzzer. They generally arrive quite quickly, but they always seem too busy and I feel I'm bothering them." Staff told us they felt that some days were busier than others and an extra member of staff would be beneficial. They were aware people were having to wait for support, especially at mealtimes. One said, "We start the shift running."

We observed there were enough staff on the ground floor to meet people's needs. The atmosphere was calm, staff were relaxed and they interacted with people, as they went about their work. However, on the first floor, although no one was calling for assistance or appeared distressed, we observed that some people had to wait for staff to help them. For example, one person who required assistance to eat their meal, was brought into the dining room and had to wait for over an hour for a staff member to bring their meal and to help them. They were able to see other people having their meals and smell the food. However, they were not distressed by this and sat quietly watching what was going on. At lunchtime, there were five people who required the support of staff to eat their meal. Only three staff were available to do this and one of those was plating meals for people, including those people in their rooms. Once finished the staff member assisted people to eat. People were assisted unhurriedly and had the full attention of the staff member while they were being assisted.

We saw from rotas that the ground floor nursing unit was staffed during the day by one registered nurse and three care staff supporting fifteen people. The first floor dementia unit was supported by one registered nurse and five care staff. Staff told us the majority of people required two care staff to meet their care needs. Two staff members were undertaking on-to-one support. This meant that three care staff were supporting seventeen people. Staff said the night staff supported those people who liked to get up early but that still meant there was a high number of people requiring support from the three staff.

A dependency level tool was used by the manager to calculate the staffing levels required to meet the needs of people who lived in the home. This information was intended to help the care home manager to provide good quality care for people by supporting decisions on the overall staffing of the home.

We discussed the dependency tool with the manager who told us they would check how staff were deciding

on the dependency levels of people in light of comments received to ensure they were being completed correctly and staffing needs correctly assessed.

We recommend the provider reviews their dependency tool and the number of staff supporting people in the dementia care unit, to ensure people's needs are met in a timely way.

People were protected because staff understood their roles in safeguarding people from abuse. Staff had received training in safeguarding adults and information on how to raise safeguarding concerns was available. At the time of our inspection, staff had not had to raise concerns with the local authority safeguarding team but we saw evidence of the provider working with social services where there had been a concern. There was a clear safeguarding policy in place and staff demonstrated a good knowledge of how to raise any concerns. One staff member said, "I'd report it immediately after making sure the person was safe."

Records showed accidents and incidents were recorded and reported. Appropriate actions were taken such as first aid being applied and referrals being made to other health care professionals. Accidents and incidents were analysed in a way which enabled trends to be identified and action could be taken to reduce risks.

The provider ensured the safety of the premises. Regular checks were carried out on the health and safety of the building and maintenance works were actioned where improvements were identified. The safety of the building in the event of a fire had been assessed. The provider had plans in place for in the event of a fire and equipment in place to support staff. Each person had an individual personal emergency evacuation plan (PEEP). PEEPs reflected people's needs and guided staff on how to best support them in an emergency. Staff were trained in fire safety and regular drills were conducted.

The environment at the home was clean and well maintained. People were protected from the spread of infection. Staff had received infection control and food hygiene training and understood what actions to take to minimise the spread of infection. During the inspection the home was affected by a stomach bug. The home acted appropriately to minimise the spread of the infection and followed advice from Public Health England. Audits and monitoring ensured good practice was followed throughout the home. We saw that personal protective equipment was available for staff. Staff told us they used aprons and gloves when assisting with personal care.

Good

Is the service effective?

Our findings

People and their relatives told us they felt staff were effective in meeting their needs and had the necessary skills to provide the care they needed. One person told us, "They (staff) look after me very well." One relative described their relative's care as "brilliant" and said how much they had improved since moving to the home.

Staff said they were well supported in their role. They described a team that worked well together. Comments from staff included, "This is a nice place to work" and "It's a nice team here and the training has been good."

New members of staff completed an induction programme, which included being taken through all of the home's policies and procedures, and training to develop their knowledge and skills. Staff then shadowed experienced members of the team, until both parties felt confident they could carry out their role competently. The staff training records demonstrated that staff had received training in essential topics such as fire safety; moving and handling; safeguarding, first aid; food hygiene and infection control. Staff told us they enjoyed the training and it enabled them to meet the needs of people living at Belle Vue.

Staff also received training specific to the needs of the people they supported. One staff member told us they were supported to attend additional training to meet the needs of people living with epilepsy. The provider encouraged staff to complete health and social care qualifications, such as Qualifications and Credit Framework (QCF). QCF is a further qualification in adult social care and equips staff with a better understanding of the care industry.

Staff received regular one to one supervisions and appraisals with their manager where they could discuss their performance and their skills development. Supervision sessions between care staff and their manager give the opportunity for both parties to discuss performance, issues or concerns along with developmental needs. Staff said they felt able to raise any queries or concerns informally at any time with the manager or nursing staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People's legal rights were protected because staff followed the guidance of the MCA. People's care records contained evidence of mental capacity assessments that were used to assess people's ability to make specific decisions. Where people were unable to make decisions, best interest decisions were documented. For example, one person had been refusing to take their medicines. They had been assessed and did not have the capacity to understand the consequences to their health if they did not take their medicines. A best interests meeting involving staff, the person's GP and family members had been held to discuss whether it

was in the person's best interests to have the medicine hidden in their food.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people were having their movements restricted to keep them safe, the manager had made appropriate applications to the local authority to deprive them of their liberty.

People had enough to eat and drink. Comments included "The food here is very good. We have a hot meal for lunch and sandwiches for tea. Breakfast is always a treat and very generous", "I like the choice of meals, and how much is provided" and "The food is good and always plenty to eat and drink." We saw tea, biscuits and fruit were available to people throughout the day.

We observed the lunchtime meal and saw the food was freshly cooked, looked hot and appetising and people seemed to enjoy it. Some people didn't want anything to eat but were gently persuaded by staff eat a little and to have dessert. People were given choices of what to eat and staff checked with people if they had had enough to eat and drink. One staff member said when giving a person their tea, "Let me know if it's not sweet enough and I'll give you more sugar." Some people required support to eat their meals. We saw staff sat alongside people giving them their full attention and offered assistance in a patient, respectful and encouraging manner. Staff engaged them in conversation and did not rush them with their meal. Some people were given adapted crockery to support their independence with eating. People were able to give their views about the food and these were taken into account. The chef told us they regularly spoke with people to hear their feedback about the food and planned the menu based on people's views. People's nutritional needs had been assessed before they moved into the home and were kept under review.

People were supported to attend health appointments to maintain their health and wellbeing. Staff involved healthcare professionals appropriately when needed, such as; speech and language therapists, podiatrist and tissue viability nurses. Where advice was given, we saw this was followed.

People's individual needs were being met by the design and adaptation of the premises. The home was undergoing full refurbishment to create an atmosphere that was warm, homely and comfortable. All of the communal areas, corridors and bedrooms were in the process of redecoration and new furniture had been purchased throughout the home. Plans were in place to improve the dining room to enhance people's dining experience and create communal space on the ground floor for people to have access to the recently landscaped gardens. Some people at the home were living with dementia. The environment was being adapted to make it more stimulating and meet the needs of people living with dementia. For example, there were items of interest around the hallways; a mirror with necklaces and a tie for people to try on and to see themselves, soft toys, hand held musical instruments such as tambourines and bells, and twiddle mits. Memory boxes were outside people's rooms.

Good

Is the service caring?

Our findings

People and their relatives said staff were polite, caring, friendly and respectful. Comments included, "The staff are very good with the residents, people are happy living here. I think they are well cared for", "Staff are all very kind and caring and will do anything for them" and "The attention we get from all of the staff is excellent."

People benefitted from staff that knew them well and understood their personalities. Whilst there was some use of agency staff in the home this had decreased significantly in recent months and there were more staff employed in permanent posts. People knew the staff that supported them and it was clear from our observations that people, staff and relatives had formed positive relationships, resulting in a friendly and happy atmosphere within the home. For example, we observed one member of staff dancing with a person. They were both laughing and thoroughly enjoying each other's company.

People were treated with kindness and compassion and staff talked with them in a courteous and respectful manner, explaining what they were doing and giving reassurance when needed. For example, when one person became distressed during lunch, staff knelt down next to them, put an arm around them and asked what was upsetting them. Staff reassured them and the person responded positively to this and became more relaxed.

We observed staff communicated with people in the way best suited to their needs. Staff used a variety of communication methods including touch, facial expressions, and spoken English. Some information about the home was made available to people in user-friendly formats, for example in
pictorial form, or with the use of symbols. The manager told us they were planning to have all information in accessible formats. This would help to ensure people were kept informed about events at the home and able to play an active role in these if they wanted to.

People were treated with dignity and respect. Staff had completed 'dignity in care' training and this was reflective of their practice when supporting people. They were attentive to people's needs, spoke discreetly when discussing people's personal matters and ensured people were provided with privacy when personal care was provided. One person told us staff always ensured their door was closed and they were covered up as much as possible when they supported them with personal care. This maintained people's dignity and right to privacy.

People looked well cared for with clean clothes, hair and fingernails. People were all smartly and appropriately dressed and glasses and hearing aids were being worn. Some people had items with them for comfort.

People had been supported to make some decisions about their care. Where people did not have the capacity to make decisions their relatives had been consulted about their care plans at regular care reviews. One relative told us about their family member's recent review, "[manager's name] came in to do a review and included [name], talking to her throughout even though she couldn't make any decisions for herself. I

thought this was really lovely and person centred." Staff were seen to consult people before offering any support and this approach helped ensure people were supported in a way that respected their decisions, protected their rights and met their needs.

Staff received equality and diversity training to ensure they understood how to protect people's rights and lifestyle choices. The manager and staff said people would not be discriminated against due to their disability, race, culture or sexuality. Care plans recorded important information about people's relationships with others and those important to them.

Requires Improvement

Is the service responsive?

Our findings

People told us they received care and support which was responsive to their needs. One relative said, "Belle Vue was recommended to me and I've been very impressed with the lengths they've gone to in making us welcome."

Assessments were carried out to identify people's needs and they included information about their medical conditions, dietary requirements and daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, communication and moving and positioning needs. Some care plans contained personalised information such as; what people liked to wear and programmes they preferred watching. We saw examples where people's care reflected their preferences and as what was documented in their care plans. For instance, one person's care plan said they liked to watch sports and we saw them watching the athletics on television during the inspection.

However, care plans did not always include sufficient information about people's preferences around how their care should be delivered or what the person could do to maintain their independence. For example, one person's care plan said "full assistance needed with personal care" and "routine is of the utmost importance to him, to maintain his independence." Although the care plan contained some information, it did not give staff guidance about the person's preferred routine or instructions about what staff needed to do to deliver the care in the way the person wanted.

People's diagnosis of dementia was mentioned throughout their care plan. However, care plan's did not contain sufficient information about how the person's dementia affected their lives and the steps staff should take to promote the person's well being. A person centred dementia care plan based upon an assessment of the individual's needs and behaviours, would help ensure the person received effective care. This would help to promote their well-being and help the person gain as much pleasure and stimulation as possible from each day.

Care plans relating to people's behaviour management did not always contain personalised information such as, specific triggers for any distressed behaviour to enable staff to recognise them and offer appropriate intervention. For example, one care plan stated the person could become distressed and anxious but did not guide staff on what needed to do be done to de-escalate the situation. There was no information on why the person may present with distressed behaviour such as being in pain, unwell or having a low mood.

Although care plans did not contain sufficient levels of detail, the impact was minimised because staff knew people well. One relative told us, "Staff understand the triggers that can cause [name] to become upset and show that upset in aggressive behaviour. Because they understand, the number of incidents has reduced significantly. Staff know [name] doesn't like a lot of people around him, and they make sure they give him space." However, whilst current staff knew people well, the home was recruiting new staff who would not have this knowledge and would rely on care records for this information.

Records showed that monthly assessments of people's needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations included information about people's progress and well-being. Reviews of people's care plans took place with people or their representative, wherever possible. Daily records of people's care and support were held within care plans. However, we found that daily records were very clinical, task focused and lacking personal detail. They did not contain any information about how people passed their day, what activities they had completed and how staff had met their care needs.

The provider had failed to ensure accurate, complete and contemporaneous records were in place for each service user. This was a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The management team told us they were introducing a computer based care planning system in May 2018. They told us they were taking this opportunity to carry out a full review of each person's care plan. The updated records would give staff detailed guidance about every element of people's care and support needs, both physically and emotionally.

People told us that some activities were available at the home; however the majority said that more activities would be welcomed. Comments included, "There's not much to do here. No quizzes, music events, craft events or trips out", "There aren't any trips out arranged for us. I haven't even been in the garden. I am left in my room for long periods of time" and "In some ways it's absolutely wonderful, all of the attention we get, but there is nothing going on in the afternoons. You need something to stimulate you." Staff told us they did not have much time to sit with people and provide one-to one activity.

People were not receiving person centred care designed to meet all their needs, including emotional and social needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a timetable of activities was available and this covered a variety of different types of activity, for example; music, exercise, arts and crafts, games and themed events. During the inspection we saw people enjoying an animal visit where they were able to hold and stroke the animals. Staff took animals into people who stayed in their rooms, so they would be involved in the activity. The home celebrated calendar events such as; Easter, Christmas, Mother's Day and Father's Day by decorating the home for each occasion. We saw photographs of people enjoying activities and arts and crafts made by people, were displayed around the home.

We discussed the provision of activities with the manager and regional manager. They told us they had identified the provision of activities needed to be improved. They told us about the steps they were taking to improve this aspect which included the introduction of memory boxes, themed areas and activity stations to aid reminiscence and prompt conversations with people living with dementia. The gardens had been developed to make them more accessible to people and plans were in place to improve access to the gardens from the home. The home also had shared use of a minibus and trips out were being planned for the future. The home was also looking at local resources available. For example, they had strengthened links with local schools and were arranging for children to come into the home to read and spend time with people.

People were supported to maintain their faith and cultural identity. A vicar from a local church visited the home monthly and people were also supported to maintain their links with their chosen church or faith group. Staff discussed people's faith and cultural needs with them and every effort was made to ensure this

was met.

People's end of life wishes were discussed with them and their needs and choices recorded in their care plans. This ensured that people's final days were as they wished for and their choices known and respected. At the time of our inspection no one was receiving end of life care, but policies and procedures were in place. Staff told us they had received training on end of life care and were supported by the local hospice when necessary.

People's communication needs were identified through the assessment process and care plans identified how staff should communicate with them. Where necessary information was provided in different formats, such as large print, for those people with a sensory impairment. Some of the people at the service had limited skills understanding correspondence due to their dementia. When people received correspondence staff would read this to them.

People and their relatives told us they would speak to the manager if they had any concerns or complaints. The manager told us complaints were welcomed and would be used as a tool to drive improvements in the home. Records we reviewed showed there were systems in place to respond to complaints and concerns in a timely way. We saw all complaints received had been responded to appropriately and any learning had been shared with staff to prevent re-occurrence.

Requires Improvement

Is the service well-led?

Our findings

Belle Vue is owned and run by Harbour Healthcare. They were registered as the providers of this service in November 2017. A nominated individual had overall responsibility for supervising the management of the home.

Since the provider took over the home in November 2017, the registered manager at the time, resigned from their position. The provider appointed the deputy manager as interim manager, supported by senior managers, whilst the provider was in the process of recruiting a replacement. The newly recruited manager took up their position during the course of the inspection.

Management systems and processes were in place for the governance of the home. Audits were used to monitor quality and included senior management oversight to ensure that complaints, incidents and accidents were analysed. These systems were devised to help drive improvements.
Although some quality assurance systems were working well, others had not been effective in identifying the areas for improvement that we found at this inspection. For example, oversight and checks by staff had failed to identify that records did not demonstrate people were receiving regular repositioning to mitigate the risk of skin damage. Auditing systems did not identify that some care plans and risk assessments were not in place and others did not always give sufficient guidance for staff to provide personalised care.

Although, the provider had a recruitment procedure and policy in place, the quality assurance systems had not identified where checks had not been completed. This meant they did not have a robust system in place to ensure all staff recruited were safe to work with people who were at risk.

Failure to ensure systems were effective in assessing, monitoring and improving the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we discussed our findings with the manager and regional manager. We found they were open and transparent throughout the inspection and sought feedback to improve the service provided. The management team were keen to demonstrate they were using feedback to continue to learn and improve the service they provided. The regional manager told us that since the provider took over the home in November 2017 they were working hard to improve standards of care quality for people living at Belle Vue. They recognised that they were still in the early stages of improving the quality of care.

The provider had introduced up to date policies and procedures to guide staff and improved care planning and care monitoring tools. They had invested in electronic care plans which were being introduced in May 2018. In January 2018, the provider had commissioned an independent external care quality audit and was working on their recommendations. We saw results and findings from audit programmes informed their development and improvement plans. Actions from these were then overseen by the manager and regional manager to ensure they had been met.

The regional manager told us they were working hard to improve care by recruiting the right staff with the

right skills and caring attitude. They were currently looking to recruit two experienced registered nurses with excellent standards of nursing and dementia care as 'unit leads'. These 'unit leads' would strengthen the management team and lead excellence within the home.

People lived in an environment which was positive and inclusive. The provider's vision and values said they were, "Dedicated to delivering excellent care and services to all residents and aspiring to be 'outstanding' in all areas". Harbour Healthcare aim to provide comfortable homes and employ teams with a 'heart' for caring. During our inspection, the manager and staff team displayed through their interactions this philosophy of care.

People, relatives and staff were all very positive about the interim manager and new manager and the changes they had made since they started working at the home. They described the management as visible and approachable. Relatives told us they had noticed improvements and were happy their loved ones lived in the home. Comments included, "I can't fault the management. Nothing is too much trouble", "I think things are improving under [interim manager's name]" and about the new manager, "Things are better. I think she is a good manager. Charming and always smiling."

People benefitted from a staffing structure which made sure all staff were aware of their roles and responsibilities. Staff told us they enjoyed working in the home and felt well supported by the management team. One staff member said, "It's improving all the time. We get a lot more support now and the home is more settled." Staff described the new manager as "approachable" and said they were making a positive change to the home even though they had only been in post for six days.

There were systems in place to support all staff. Staff benefitted from an improved training programme and an employee recognition scheme was in place to recognise and reward outstanding staff. Staff meetings took place regularly. These were an opportunity to keep staff informed of any operational changes. They also gave an opportunity for staff to voice their opinions or concerns regarding any changes. Staff told us they felt comfortable raising concerns with the manager and found them to be responsive in dealing with any concerns raised.

The management team had recently introduced daily 'stand up meetings' where senior staff on duty came together to discuss the days' events, any concerns and plan care for that day. This ensured the manager and senior staff had full oversight of the home and people's care.

The provider had a whistleblowing policy, which supported staff to question poor practice. Staff confirmed they felt safe to raise any concerns and felt confident the management would act on their concerns appropriately.

The home worked in partnership with other organisations and professionals to make sure they were following current practice, providing a quality service and the people in their care were safe. These organisations and professionals included social services, the quality improvement team, healthcare professionals such as GP's and speech and language therapists. Social care professionals who had involvement with the home confirmed to us, the quality of care had improved. They told us the provider was receptive and open to suggestions.

There were systems in place to ensure the provider sought the views of people living at the home and their relatives on the service they received. Regular residents and relatives meetings had recently been reintroduced. Satisfaction surveys were also carried out. The regional manager told us they were revising the survey forms as they were not particularly user friendly and they had had a poor response. However, from

compliments and cards received at the home we saw positive comments had been received from people which included, "Many thanks for all the kindness and care you gave to my mum over the past year" and "All staff are extremely helpful and friendly."

Services providing regulated activities have a statutory duty to report certain incidents and accidents to the Care Quality Commission (CQC). We checked the records at the home and found that incidents had been recorded and reported to CQC correctly.

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 9 HSCA RA Regulations 2014 Person-centred care People were not receiving person centred care designed to meet all their needs, including emotional and social needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure all risks to the safety of people receiving care and treatment were appropriately managed and mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been operated effectively to assess, monitor and improve the safety of the services provided, or mitigate the risks. Accurate, complete and contemporaneous records had not been kept for all service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not protected by safe recruitment practices. The provider was not meeting the schedule 3 requirements of the Health and Social Care Act 2008 (Regulated Activities) 2014 to ensure that staff employed were safe to work

at the home.