Four Seasons Health Care (England) Limited

Belle Vue Care Home

Inspection report

8 Belle Vue Road
Paignton
Devon
TQ4 6ER

Tel: 01803522112
Website: www.fshc.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 18 July 2016. The inspection started at 06:25 am to allow us to meet with the night staff.

Belle Vue Care Home was last inspected on 10 June 2015. The home was rated as 'requires improvement' across all key questions at that time. Since the last inspection there had been some improvements at the home, such as the new corporate care planning systems and improvements to the staff recruitment files. However, we identified a number of concerns and breaches of legislation on this inspection in July 2016, many of which had also been issues at the last inspection which had not been resolved. Many of the issues were related substantially to the first floor dementia care unit. At the start of the inspection the registered manager had told us they were confident that the issues raised at the last inspection had been resolved.

Belle Vue care Home is a purpose built care home registered to provide care for up to 52 people. The home is set over three floors, with people receiving general nursing care on the ground floor and a locked dementia and mental ill health unit on the first floor. The lower ground floor contains service areas, such as the kitchen. People living on the ground floor had significant physical ill health and were mainly older people.

The home has a registered manager. 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 identified some concerns around people's safety. People were not being protected from the risks associated with medicines. Nursing staff were not following safe practices when giving people their medicines, although this was addressed at the time of the inspection.

We found the environment was not always safe for people. Some areas of the home needed additional cleaning or maintenance, and there was a significant odour problem on the first floor dementia unit. The dementia unit had not been adapted to reflect best practice in dementia care. For example, information was not always provided to help people maintain their independence or orientate themselves to their environment. However the provider was about to deliver a dementia training package to all staff to improve the outcomes for people in this area. Work was also due to take place to make changes to the environment to make this more suitable for people's needs. Staff who had been involved in this already were enthusiastic about it.

Risk assessments were not always in place or in sufficient detail to help keep people and others safe from risks associated with their care. We have made a recommendation in relation to the recording and monitoring of pressure ulcers in line with good practice. This would ensure that any progression or deterioration of the wounds was clearly and objectively recorded for example with photographs. Pre-

admission assessments had not always been undertaken thoroughly and incidents had not always been properly assessed so had not always been escalated appropriately. This had meant that people had been exposed to risks from other people in the unit. This had been resolved at the time of the inspection.

There were not always enough staff on duty at all times to ensure people received the care, support and observation that they needed. Staff competencies or practice were not always being assessed appropriately. Although staff were receiving training it was not always clear that this was improving people's care or was being put into practice. Staff recruitment practices were safe and had been followed in the files we saw.

People and their relatives gave us mixed information about the meals being served. Some people enjoyed their meals. However we heard from relatives and staff those meals sometimes did not meet people's needs, in particular where there were specific dietary textures required. Meals served to people were not always suitable or varied. People were not always given a choice, and we did not see that people were given additional fluids, even though it was a hot day.

People's care plans were not always being followed. People's dignity was not always supported and staff did not always treat people with respect. For example, some staff communication did not support people's wellbeing, and people's personal standards of dress and self-care were not always being respected. Staff did not always respect people's privacy, and the layout of the building meant it was difficult for people's private space to be respected. Staff interactions were not always supportive to people. However we also saw some good practice, with staff interpreting people's behaviours and offering them comfort when apparently in pain.

A new activities organiser had been appointed and was getting to know people and their wishes regarding activity before commencing a new programme of activity. However we saw little evidence that people's wishes regarding activity or interests had been respected.

People's rights regarding capacity and consent were being respected and staff had a good understanding of issues in practice. Applications had been made for deprivation of Liberty safeguards where needed. People had access to community healthcare services to meet their needs, and community staff told us that communication with the home was good.

There was not a positive culture at the home, and a tolerance of poor practice. Leadership was poor and management had not been effective at identifying concerns or addressing them. Some organisational policies and procedures in place to keep people safe and promote high quality care were not being followed in practice. For example staff had received training in safeguarding people, and told us they understood how to report any concerns about their welfare. However we saw an instance where staff subjected a person to degrading treatment. Improvements identified as needing to be made following the last inspection had not altered some of the practices we saw.

Records were not all well maintained. Some entries were not legible and some policies and procedures were not reflective of current practice, for example the complaints procedure.

We identified a number of breaches of regulations during this inspection. You can see what action we told the provider to take at the back of the full version of the report.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

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.

People were not being protected from the risks associated with medicines.

The environment was not always safe for people.

Risk assessments were not always in place or in sufficient detail to help keep people and others safe from risks associated with their care. We have made a recommendation in relation to the recording of pressure ulcers.

There were not always enough staff on duty at all times to ensure people received the care, support and observation that they needed. A full staff recruitment process had been followed.

Staff understood how to keep people safe and how to report any concerns about their welfare. However incidents had not always properly been assessed so had not always been escalated appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

Meals served to people were not always suitable or varied. People were not always given a choice.

Staff competencies or practice issues were not always being assessed appropriately or poor practices challenged. Although staff were receiving training it was not always clear that this was improving people's care or was being put into practice.

Belle Vue was a purpose built care home. However parts of the building, in particular the dementia care floor were not supporting best practice in dementia care. This area had a significant odour problem.

People's rights were being respected and staff had a good understanding of capacity and consent issues. Applications had been made for deprivation of Liberty safeguards where needed.

People had access to community healthcare services.

Is the service caring?

Inadequate

The service was not caring.

People's dignity was not always supported and staff did not always treat people with respect.

People's personal standards of dress and self-care were not always being respected.

Staff interactions were not always supportive to people. Information was not always provided to help people maintain their independence or orientate themselves to their environment.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always being followed. Pre-admission assessments were not thorough enough to identify people's needs or risks from their care.

People did not benefit from appropriate, stimulating activities in accordance with their wishes. A new activities organiser had been appointed and was getting to know people and their wishes regarding activity.

Systems were in place for the management of complaints. However people told us that sometimes minor issues had not been resolved in a timely way.

Is the service well-led?

Inadequate

The service was not well led.

Action plans identified to address concerns from the last inspection had not been effective in making the changes needed. Some regulations breached at the last inspection were still not being met.

There was not a positive culture at the home. Leadership was poor and management both within and outside of the home had not been effective at identifying concerns or addressing them.

Quality and some safety issues were not being addressed.

Records were not all well maintained.	

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 the 18 July 2016 and was unannounced. The inspection started at 06.30am to allow us to meet with the night staff and observe activity at the home first thing in the morning.

The inspection was carried out by one adult social care inspector, an adult social care inspection manager and a specialist advisor. The specialist advisor had recent professional experience in the management of nursing care, including pressure ulcer management and management of long term health conditions.

We looked at the information we held about the home before the inspection visit. We contacted the local authority quality team to gather information they had about the service, and the older person's mental health team and tissue viability service from the local care trust for their views on the home. We looked at information the provider had sent us in a provider information return (PIR), and concerns, complaints and notifications that we had received since the last inspection.

We spent time observing the care and support people received, including staff supporting people with their moving and transferring. The majority of people living at the home were not able to share their views with us about their experience of care at Belle Vue. We spent several short periods of time carrying out a 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. On the inspection we spoke with or spent time with seven of the 48 people who lived at the home, seven visitors, and nine members of both day and night staff. We spoke with the staff about their role and the people they were supporting. We also spoke with the registered manager, regional manager who attended the home and a visiting professional from the intermediate care team.

We looked at the care plans, records and daily notes for six people with a range of needs, and looked at other policies and procedures in relation to the operation of the home, such as the safeguarding and

complaints policies. We looked at four staff files to check that the home was operating a full recruitment procedure, and also looked at their training and supervision records. We looked at the accommodation provided for people and risk assessments for the premises, as well as for individuals receiving care and staff providing it.

Requires Improvement

Is the service safe?

Our findings

We found that the service was not always safe.

Risks were not always being identified or managed well. We identified risks from the environment, medicines and in relation to people's care.

People were not being protected from risks associated with medicines. We observed nursing staff giving people their medicines and looked with the regional manager at the arrangements for the management of medicines on both floors of the home. Nursing staff were not using the lockable medicines trollies to take medicines to people. We saw one nurse had removed medicines from their original dispensing containers and put them into unlabelled pots to take to multiple people at the same time. We asked the nurse how they knew who each of the medicines were for and they said they were "familiar" with the medicines so knew who to give them to. People were at risk from being given the incorrect medicines, and this practice was contrary to the Royal Pharmaceutical Society guidance on secondary dispensing. This administration was stopped at the time of the inspection, and the medicines were destroyed. New medicines were dispensed for each person and administered in accordance with good practice. We observed another nurse carry a medicine to a person in their hand, and put the medicine into their mouth using their fingers. This medicine was a large tablet. The person was living with a dementia and had difficulties in swallowing. The person was not observed following being given the tablet to ensure they did not choke.

Medicines were not being stored safely. Some medicines were being stored in unlocked cupboards in the clinical rooms, including medicines that needed particular security due to their strength or effects. Others had been left out on the worktop in the clinical room, including insulin and medicines awaiting return to the pharmacy. The medicines fridge was being used for other purposes as well as the storage of medicines needing to be kept cool.

Some protocols for the administration of 'as required' medicines were not in place or were not clearly recorded. For example one person was prescribed a medicine to help manage their anxiety or behaviour that might present risks to themselves or others. The instructions stated ½ a tablet could be given twice a day. But this did not include clear guidance on what minimal interval should be left between doses, which could lead to the person having more medicine than was safe for them.

Prescribed dietary supplements had been left out in a dining room. The prescription labels had been removed so it was not possible to see who they had been prescribed for or were being given to. A fluid thickening agent prescribed for people with swallowing difficulties had been left out in a dining room. This had also had the prescription label removed, and could have presented risks to people if ingested.

Risks presented by people with distressed behaviours were not always effective or accurately assessed or mitigated by the home. An incident between two people living on the unit where one had pushed the other over had been triaged by the service as a fall rather than as an incident of abuse or assault. This meant that the incident, which was one of several similar incidents, had not been flagged up to management at the

appropriate level of concern, and had meant that concerns over risks presented by the person who had caused the incident had not been correctly identified.

Not all injuries to people were being recorded or investigated thoroughly. We saw one person had bruising on their arm and forehead, and spoke with a nurse about this. The nurse said she thought the bruise on the person's forehead had occurred because the person liked to walk around and may have bumped their head. The person's relative also said this was likely how this had happened. Records showed staff had noted the bruise on their forehead, but not the bruising on the person's arm.

The provider's PIR indicated that improved risk assessments regarding people's care needs were included in the new care planning process. However we found risks were not being mitigated because the pre-admission risk assessment processes in place were not always robust.
For example, the admission of a person recently to the dementia unit had introduced some risks to the service and to other people which staff said had been a challenge to manage. Records showed that prior to this emergency admission the person's assessment had identified this person had behaviours that may pose a risk to themselves or others. These had been managed in the person's previous home by them having one to one care. This had not been arranged when they were admitted to Belle Vue. We were told the manager had made the decision to admit this person prior to the assessment being carried out by a nurse. During their stay at the home, one nurse reported to us they had been hit and a carer reported they had been slapped by this person. The person had been moved to another service by the time of the inspection. We asked the visiting regional manager to look into the circumstances around this placement and the risks that had been introduced to the home through the lack of assessment and planning about the risks presented by this person.

One resident, who was in an intermediate care bed and was in the planning stage of going home, was self-administering their prescribed insulin. This was good practice, however there was no risk assessment in place to document that the staff were carrying out safe practice or demonstrate that the person was able to self- medicate safely.

People were not always being protected from risks within the environment. Some areas of the home were not clean and had a strong odour of urine. The central garden area was not safe for people to access independently. We found trip hazards and broken furniture in this area. Staff told us they had cleanliness concerns over the manager's dog. We identified that not all windows had appropriate restrictors to ensure people's safety.

The failure to manage medicines safely and the poor management of risks is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe Care and Treatment). This was also breached at the last inspection of the home in June 2015.

The regional manager who was at the home to support the inspection took immediate action to address the concerns about medicines.

We did not find that there were enough staff on duty at all times to meet people's needs. Staff told us they did not feel there were always enough staff on duty. This was because the people across both units had very high needs. The provider used a staffing analysis tool to identify the levels of staff needed on each shift based on the number and dependency level of people living at Belle Vue. The staff on duty on the day of the inspection did not always reflect the tool's recommendations for staffing. For example the staffing tool indicated that in the dementia unit five care staff and a registered nurse were needed on a morning shift. On the week of the inspection there were five care staff on duty three mornings, but on the other four mornings

there were only four care staff and the registered nurse. The registered manager told us in their PIR that this assessment was updated monthly.

We saw that many people were left for long periods in their rooms without any stimulation or company. On the dementia care floor we saw people who were unobserved or unsupported for long periods despite their care plans saying they needed close observation. For example, we saw one person wandering the unit unobserved by staff and then urinating in a corner of the foyer. This person's care plan stated "Staff need to encourage (person's name) to use the toilet any time (person's name) needs" and that the person needed "orientation and reminding by staff where the toilet is" and "constant supervision and 1:1 attention". However no staff were available to support the person as they were all engaged in getting people up. We also observed that people who were up at 7am had still not been given a drink by 8.45am, as staff were busy elsewhere. Staff on the ground floor unit told us they were often required to work on the first floor dementia unit to cover when they were short of staff, and several staff told us that cover was not always provided when staff went off sick. Staff told us they worked long shifts of up to 12 hours, and requests to change shift patterns were not always respected.

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

We saw evidence of good practice regarding moving and positioning of people. Plans, guidance for staff and risk assessments were in place in each person's file. Bed rail assessments had been completed. Pressure area care and assessments were up to date and had been regularly reviewed. These were in line with community nurses assessments, which showed the home's staff had a good and up to date knowledge of risk assessments in relation to pressure damage. Staff had a good understanding of pressure ulcer prevention. However plans did not contain photographs or descriptions of the wounds which would be good practice and there was poor understanding of the appropriate settings for pressure relieving equipment.

We recommend that the home follow good practice guidance in relation to the documentation and monitoring of pressure ulcers.

We also saw some occasions when people's needs were attended to in a timely way, and where staff noticed if people needed additional support. We saw one person indicated they needed to go to the toilet. A staff member reminded them of where this was and waited for them to come back to ensure their clothing had been re-adjusted. This suggested that staffing shortfalls may be related to certain times of the day.

People were not all able to tell us they felt safe, however relatives said they felt confident staff were looking after people well and that they were safe from harm. Staff told us they had received safeguarding training and knew who to report any concerns to. They were confident the nurses or manager would take action. Safe systems were in place for the management of any monies held in trust by the home. There was a safeguarding flow chart available to help staff understand what actions to take if they had concerns over people's wellbeing or abuse, and a safeguarding policy and procedure available.

A recruitment process was in place that was designed to identify concerns or risks when employing new staff including disclosure and barring (police) checks. We sampled four staff files, and identified a full recruitment process had been followed. Checks were made on professional qualifications and registration status for registered nurses.

People were being protected from the risks of cross infection. We saw staff wearing aprons and gloves when

supporting people and there were no known current infection control risks. We observed a member of staff cleaning up an area where there had been an episode of incontinence. The area was mopped and disinfected. Information in the home's PIR told us the home was planning to make changes and improvements to their laundry management systems.

Requires Improvement

Is the service effective?

Our findings

The home was not always effective.

We were told about concerns over the meals served to people with swallowing difficulties. Staff had attended training in supporting people with swallowing difficulties and were positive about putting their training into practice. However, staff and relatives told us that where people had been identified as needing a pureed or 'fork mashable' textured diet the meals provided by the kitchen were not always suitable or did not meet the advice supplied by the speech and language service. The meals presented were not always provided in ways that met the person's individual needs or preferences. For example, one relative told us about a cheese dish which had such a hard crust, it could not be eaten. Staff told us they had raised concerns with the catering team and manager but the issues had not been resolved, and that there was poor communication between the chef and care staff. The manager told us they were not aware of the concerns. The chef and catering team had not attended the swallowing difficulties training with other members of the staff team. We saw that the pureed vegetables in a meal were not always presented separately to people on soft diets. This meant people did not have opportunities to experience different tastes as a part of their meal.

We observed people over a breakfast and lunchtime in the dementia unit. We did not find that the design of the unit or way that meals were served helped ensure people had a positive experience. The dining room was noisy, and people were not always supported well by staff to eat their meals. This meant some people were constantly walking about and distracting other people trying to eat. We saw one person eating scrambled egg with their fingers. The person did not have clothes protectors or anything to wipe their hands on. Another person attempted to take one person's meal from them at which point staff intervened. We observed a member of staff helping a person to eat. They gave the person a spoonful of food and then left them while they went and gave someone else their meal. They then returned and gave them another spoonful until the meal was finished. This did not help the person engage with their meal or have an enjoyable mealtime experience. The care delivered to people over the mealtime was not meeting their individual needs or supporting their well-being.

Some relatives told us the quality and variety of food could be improved. For example, a relative told us the sandwiches at tea time were always the same. They told us sometimes they put two different types of sandwiches together, to add some interest or variety.

The day of the inspection was very hot, however we did not identify that additional fluids had been provided for people. We saw instances where drinks had been left in people's rooms but were out of their reach. We saw one person was given some medicine with a small amount of water, which they drank really quickly. The staff member said to the person "You are thirsty" but made no effort to arrange for the person to have a drink bought to them. This did not support the person's well- being.

The failure to meet people's individual needs and support their well-being in relation to hydration and nutrition is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Assessments made by the speech and language service and their recommendations were maintained in their care files. Staff demonstrated that they knew who had what type of textured food and thickened liquids and some information was on display in the dining room.

We did not always see people being offered choices with their food, but we did see people being given additional helpings if they wanted them. Two relatives told us that staff understood some people liked to walk or move around and needed encouragement to stop and eat, or to eat on the move. They said that this support was given and their relatives were maintaining their weight.

We also saw some people enjoying their meals and snacks. One person told us "The food is quite good, better than in hospital".

Staff training and support systems were not always effective. Staff told us they received training, including support to maintain their professional registration. However, they questioned the value of some of this. Staff said the majority of training was via e-learning. They said this felt like a process to be completed rather than it having a positive impact on their practice or learning.

The manager told us e-learning was useful, but that it should be backed up by checking staff practice to ensure they were competent in their role and put their training into practice. The manager told us they thought this did take place on occasion, to ensure the training had the desired effect but there were no systems, records or other evidence to show this happened or record of changes that staff had made as a result of the training they had received.

Staff received supervision on a one to one basis. However, each supervision was not always linked to the previous supervision. For example, where areas for improvement were identified these were not always discussed or reviewed at the next supervision meeting. Actions relating to improvements that had been identified were general and could not be measured. For example one staff member wanted to improve their English. The action identified in their supervision record was "to try and improve English ", and the reason identified was so the staff member could better communicate with people living at the home. At the next supervision meeting the supervisor had recorded the staff member's communication was satisfactory and they could communicate with other colleagues and nurses. There was no mention if their English had improved in a way that helped the staff member to communicate with people living at Belle Vue. This told us the supervision practice undertaken was not effective in ensuring staff had the competencies they needed to carry out their role.

One member of staff told us they were carrying out training at work when they should have been caring for people. When we spoke with the manager about this, they told us staff could do training at the nursing home, whilst not working and were paid for this; however they should not be doing this while on the staffing rota. The nurse in charge of the unit where this was happening had not taken action in relation to this although they had seen this carer was undertaking this work in the lounge.

The manager told us the annual reviews or appraisals recorded a summary of the staff member's performance and any issues. Records did not demonstrate this. We saw that training was discussed during supervision, but this related to its completion, not to the impact it was having for people using the service. The manager said she and the nurses observed staff practice. There were no records relating to this. We observed poor practice occurring by and in front of senior staff that was not challenged, for example with regard to supporting people to eat and take medicines. Staff had received training in safe administration of

medicines, but were not following the training that they had received.

Staff did not receive the support, professional development and effective supervision and appraisal they needed to enable them to effectively carry out the duties they were employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).

Staff told us they were keen to learn and improve their practice. They said they felt the moving and handling training was very good and really helped them support people well. Staff were pleased that some new training for staff in caring for people with dementia was being introduced. Some staff had received this training already and felt very positive about it. Other staff were due to receive this training in the weeks following the inspection.

The premises did not always reflect good practice in design, especially for people with dementia, and not all areas had been well maintained. Belle Vue Care Home was a purpose built building set across three floors. The lower ground floor housed service areas; the ground floor was for people with general nursing care needs and a first floor unit for people with dementia or mental ill health. This unit was locked with the use of keypads, and could be accessed via a lift or stairs. This unit had a significant odour problem, and people living there had no access to outside space without staff support. The corridors provided space for people to walk and there were communal areas, but these were not signposted to people. There was no obvious attraction or reason for people to go there, so they were not being used much during the inspection unless staff specifically took people there. Several people however chose to sit in a foyer area, which was cramped and hot. The dining room doors were shut outside of mealtimes, which deterred people from using this bright and open area. The registered manager told us that there were plans to remove the wall between the foyer and dining room which could make this space more available and attractive to people during the day.

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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the home was working within the principles of the MCA. We found the home was taking appropriate actions to protect people's rights. Staff were aware of people's right to refuse support. We saw people being offered choices and asked for their consent throughout the inspection. Records indicated discussions had been held and best interest decisions made regarding areas where people lacked capacity to consent for example with regard to taking medicines. However we also identified a lack of a best interest decision having been recorded for one person who had transferred to the home from another service. This was raised with the area manager for their investigation and review.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications had been made for authorisations to deprive people of their liberty at Belle Vue Care Home.

People received the healthcare support they needed. We saw evidence in people's files of support from opticians, podiatry services, specialist support services such as community mental health teams and GPs. A relative told us staff always consulted them when their relation was unwell and they made referrals to their GP when needed. Visiting community staff told us they did not have any concerns about communication with the home about people's needs or about their care.

Inadequate

Is the service caring?

Our findings

The home was not caring.

We saw that although there were some areas of good practice staff did not always treat people in ways that were respectful, or supportive of their dignity. The home's website stated that "Making Care Special is at the heart of Belle Vue Care home". We did not find that had always been put into practice or reflected people's experience of the home.
We spent several periods of time throughout the day observing care delivered to people on the dementia care floor. On the general nursing floor we were able to speak with more relatives and people who could express their experiences.

On the dementia care unit we saw both positive and poor examples of care and support for people. We saw some staff attending to people in a person centred way by acknowledging their presence, attending to their distress or involving them in what the staff member was doing. We also saw staff ignoring one person who came to them seeking attention. We heard one person repeatedly asking staff to be quiet and staff not acknowledging this person.

Several people in the dementia care unit looked dishevelled and had no socks or shoes on. One person had dirty nails, and another was wearing stained clothing that did not appear to have been well cared for. Their care file under the section of "What is important to me" said their dress preference was "smart trousers and tops". We did not see that this had been respected. We heard staff calling to each other down corridors and talking about tasks they were carrying out in front of people.

We saw people's privacy was not always respected by staff. People received personal care in their own bedrooms or in bathrooms. In the morning we walked around the dementia care unit before staff were aware we were there. We walked past one person's room where the person was being attended to by two staff. The door was propped open by laundry trolleys; the person was receiving personal care and was undressed on their bed. A man who lived at the home was walking past the bedroom door and staff had made no effort to close the door or cover the person being cared for to protect their dignity. Staff were talking over the person rather than involving them in discussions about their care. This told us staff were not putting into practice training about protecting people from abusive or degrading treatment and had a tolerance of poor practice.

We saw staff repeating a person's vocalisation patterns in a mocking reflection of their speech. We also saw staff responding impatiently at times to people's requests for support or refusal to comply with staff instructions. We also saw, and relatives told us, that some people, who liked to walk around the home, would come into bedrooms uninvited. They said they were "easily moved on", but this could be a nuisance at times. This meant that people's private space was not respected.

Communication was not always at an appropriate level to support people's needs and understanding. Some signs were available to identify toilet and bathrooms, but there was no directional signage to support

people to understand where to go to find these facilities unless they came across them independently. We saw two people searching rooms before passing urine inappropriately on the floor.

Information in the PIR completed by the registered manager told us "the resident's wishes are considered and they are treated with dignity and respect at all times". We did not find that to be the case.

The failure to treat people with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Dignity and respect). We had identified concerns over a lack of respect at the last inspection in June 2015. We did not see that these had been addressed.

We also saw some instances of positive and caring support being delivered to people. We saw staff help one person by clipping their hair out of their eyes. We saw staff adjust people's clothes to ensure they were dressed appropriately after visiting the toilet. A staff member expressed concern for one person who was holding their head as if they had a headache. The person started leaning forward and resting their head on the dining table they were sat at. The staff member spoke with them and asked if they wanted to go to bed. When the person said they did not the staff member went and got them a cushion to rest their head on. They asked them if they wanted pain relief.

People in the ground floor general care unit and their relatives were mainly positive about the services they received. One relative stated that the care staff are very friendly, 'I always get offered a drink', another relative stated that they visited their relation every day and had a main meal with them. They told us "They must be kind to my wife as she always laughs when they come in her room." Another relative stated 'I would definitely recommend this home to family and friends. 'I can bring my dog into see my husband, it cheers him up. He always appears well shaven and clean. He does sometimes shout but I've been told the staff can manage." A person who lived at the home told us 'I can't fault it here, they are so kind. '

Requires Improvement

Is the service responsive?

Our findings

The home was not always responsive.

Since the last inspection in June 2015 a new corporate care planning system had been put in place. We found there was a lack of consistent robust care planning assessment processes in place in practice. For example one person had been found to have significant behavioural needs that could not be supported safely at the home shortly after their admission. This had meant they had to be moved to another placement in a crises. This told us that the systems for pre-admission assessment of people's needs were not always robust.

We identified some gaps in people's care plans where they had not been fully completed, and some information was not clear. For example, one person had a "Well being" profile which had been completed on 5 June 2016 and indicated they had a 'score' of 9. However there was no information about what that meant for the person or how it affected their care. There was no information located with this to help staff understand what the assessment meant.

Plans that we saw had been updated regularly. The PIR completed by the registered manager stated "Care plan development and reviews are discussed with the resident and or relatives on a monthly basis so that care provision can be optimised". However, reviews of people's plans were carried out by the registered nurses. We asked care staff if they were involved in these reviews and they said they weren't. They said they would like to be as they thought they had a lot to offer about how to help some people be happier. They also thought that some information they had about people, which they passed on verbally, got lost. They thought being involved in the care planning reviews would help to ensure this information was recorded and used usefully to positively impact on people's care.

People were involved in the drawing up of their care plans where possible, but we did not see that this always reflected the care and support they received. For example, we spoke with one relative who told us how one person's medical condition had affected their ability to communicate. They told us what would work when talking with this person to gain and keep their attention. This was not recorded in this person's notes and we saw staff did not communicate with this person in this way. This person often looked confused and lost because they could not understand staff.

Other people's care plans were not always being followed. For example we saw people in the dementia unit whose care plans stated they needed a high level of observation and support. We did not see this was being provided.

Staff demonstrated a good understanding of people's past and preferences. They told us about some people's behaviours and past choices and how this knowledge helped them to meet people's needs in a person centred way. However, we did not see this knowledge being used to help people remain socially active or engaged. The home's website said that "Our activities co-ordinator uses each resident's activities and social profiles to understand the hobbies and interests they love best, so they can continue to enjoy

them here". A new activities organiser had been appointed at the home. They were in their first few weeks at the service and told us they were spending time getting to know people and their needs. On the dementia unit assessments had been carried out to identify an appropriate level of stimulation and activity for the person at a level that would avoid them becoming frustrated or withdrawing. We did not see that this had been used to help staff deliver care effectively.

Information in people's care plans had not been used to support people's interests or activities to prevent frustration or engage them in positive activities of their choice. For example one person's care plan indicated they had been an 'outdoors' person who loved walking. They were active throughout the day of the inspection, walking around the unit. Their care plan said "likes the outside and will sweep up leaves, loves wildlife and nature" and suggested they spend time in the garden. The person's records did not indicate they had been outside the dementia care unit in the preceding eight months.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Person centred care). This was also breached at the last inspection of the home in June 2015.

We spoke with another relative who told us they had been involved in discussions around their relation's care. They told us that staff understood the person's needs and that the person was as happy as they felt they could be at the home.

Relatives told us they had no complaints. They said any niggles were sorted by care staff, and felt they could go to the manager if needed. However, one person said they had raised the same issue with staff repeatedly, and this had still not been resolved. They said "it's the small things I wish they would attend to". This person gave us examples of what these small things were which as they said did not affect their relative's safety, but remained important to them as a person. They said they thought staff should notice what made this person agitated and take action to address this, but didn't always do this. There was a complaints process, but this included referring complaints to the CQC rather than other more appropriate agencies. People and relatives could use the iPad system within the home's entrance hallway to record any concerns they had about the service. These were automatically referred to managers within the organisation to help ensure they were responded to correctly. Where a significant complaint had been received by the regional manager we saw this had been managed appropriately and quickly.

Inadequate

Is the service well-led?

Our findings

The service was not well led. We identified concerns about leadership, management and quality issues at the home, some of which had not been improved since the last inspection.

Belle Vue Care Home was last inspected on 10 June 2015. The home was rated as 'requires improvement' across all key questions at that time. Since the last inspection there had been some improvements at the home, such as the new corporate care planning systems and improvements to the staff files. However, we identified a number of concerns and breaches of legislation on this inspection in July 2016, many of which had also been issues at the last inspection which had not been resolved. The PIR did not provide evidence of actions taken in response to the last inspection findings. At the start of the inspection the registered manager had told us they were confident that the issues raised at the last inspection had been resolved.

We identified concerns over the management, culture and leadership of the home. We found inconsistencies between policy and practice throughout the home. There were conflicts amongst the care staff, catering and management teams which had not been managed well. We received conflicting information about the escalation of concerns. Staff told us they had been to management with their concerns but that no actions had been taken. Staff told us the manager was unapproachable and did not spend enough time out 'on the floor' to know what was going on. We saw evidence that staff were not always respected or concerns about performance managed confidentially. We did not see senior staff offering leadership on good practice or challenging poor practice out on the care floor. Guidance, policy and practice from the organisation was not always being followed. This had not been identified by the service's management through audits, observation or reporting systems.

Risks to people's health and wellbeing had not always been managed well. Risk assessment practice was not always in place or thorough. Some risks had not been identified and some incidents had not been identified or escalated properly.

Systems to manage quality and safety for people were not always effective, and where concerns were identified they had not always been addressed in a timely way, for example managing the odour problem in the dementia unit. Since the last inspection the home had introduced an tablet computer system to allow anyone such as staff, people living there or visitors to give feedback about the service. Feedback was sent directly to the service's management and escalated within the organisation if concerns were identified. The home had a series of internal and external audits carried out that were aimed at identifying the quality and safety of people's experiences. These were collated and included on the home's quality management system. However these systems had not always been effective in supporting improvement, in that they had not identified the concerns we had found, for example with regard to medicines management. This did not give us assurance that the audits had been robustly completed.

We identified that many issues that had been raised as a concern at the last inspection had not been addressed, for example the culture and practice in the dementia care unit. There was a culture of acceptance of poor standards and care on the dementia care floor. The provider had sent us action plans

telling us about the changes they were making to address concerns from the last inspection, but these had not all been actioned or had not impacted on people's experience of care. For example the updated action plan sent to us in February 2016 stated that "A consistent documentation process is in place for recording supervisions and appraisals". We did not find that to be the case. It also stated that "An action plan is devised and followed with reference to improving the activities and environment, especially on the Dementia unit". We did not find that had made any impact on the activities provided on the dementia care unit or that people were being protected any better from social isolation.

The PIR told us that 24 visits had been made by senior managers or internal quality auditors to the home to assess the quality of care provision within the organisation in the last 12 months. These had not been effective in making the needed changes from the last inspection or identifying some of the issues we saw.

The home's website stated that "Our team works hard to create a warm, homely environment". However, relatives we spoke with were not all positive about the quality of the experience they or their relation received. For example, two relatives told us the bedding did not pay respect to people living at the home. One person said the bedding was not always ironed and another said "it just doesn't look nice". We saw a duvet on a bed had been put on upside down and some pillow cases were rough due to wear and repeated washes. Two relatives told us, or showed us, flat and lumpy pillows which they felt were not good enough. One person had felt they needed to bring their own pillows in because the quality of them was so bad. Other relatives had concerns over the quality of the food. One said the home had "five star prices but not five star quality". Two relatives said it was not fair that there had been an increase in fees when clothing was lost in the laundry and bed linen was of such a poor quality.

Residents meetings took place. Six people attended the last meeting. People had reported that clothes still went missing and it was recorded this is a "work in progress". Relatives we spoke with told us clothes were lost and bedding and clothes were not always ironed. They thought this should have been addressed, as it had been going on a long time.

Other actions that had been identified that would improve the quality of people's experience at the home had not always taken place. The minutes from a management and governance meeting from May 2016 recorded the garden needed tidying. Relatives told us this area was better than it had been. However, we noted it was uninviting. It was untidy and some seats were broken and unsafe to use. There were no minutes available for the staff meetings. The manager explained these had been archived. Staff confirmed these took place.

Records were not all well completed. Some records relating to people's care needs were not legible. We spoke with the manager about this who thought this had improved. Recent records shown to us by a nurse showed this was not the case. Records did not clearly identify people's needs or strategies for support. We saw bruising on one person which was not recorded in their notes. Policies and procedures were not all accurate or up to date, for example regarding how to raise concerns about the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance). This was also breached at the last inspection of the home in June 2015.

New management arrangements were being introduced to the organisation at the time of the inspection. A new area manager had been appointed and a regional manager was providing support from another area until the new arrangements were in place. They were present at the inspection and told us they had identified many of the issues at the home in the week prior to the inspection. They took immediate action to start resolving issues we had identified, for example booking in medicines management training for staff and

ensuring a pharmacist visited the home to carry out an audit of medicines management.

A new system for assessing the quality of dementia care was also being rolled out across the organisation and was due to be started in the weeks following the inspection. This was being launched with a meeting for relatives. We saw positive feedback had been received from staff who had already had an involvement with this programme.

People gave us positive feedback about the ways staff teams worked, for example staff told us two registered nurses in particular were "very supportive and listen to us'. A relative told us "The Matron is always pleasant; she asks if we have any problems, we can talk to her."

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving person centred care in accordance with their wishes or care plans. People's care and treatment was not meeting their individual needs for hydration and nutrition or supporting their well-being. Meals provided were not always appropriate to meet people's individual assessed needs. Regulation 9 (1) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Person centred care).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not being protected from the risks associated with medicines. Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe Care and Treatment).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff on duty to meet people's needs in a timely way. Staff supervision systems were not effective in ensuring staff competence or that training had

been put into practice.

Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.(Staffing)

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always being treated with dignity and respect. Regulation 10 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014(Dignity and respect)

The enforcement action we took:

We have issued warning notices to the provider and registered manager for this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not always comprehensive or reflective of risks to people and others from their care and treatment. Incidents were not being correctly reported and escalated Risks from the environment had not been managed Regulation 12 (1) (2) (a) (b) and (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe Care and Treatment).

The enforcement action we took:

We have issued warning notices against the provider and registered manager for these breaches

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems had not been operated to assess, monitor and improve the quality and

safety of the services provided.

Improvements had not been made to the service to reflect concerns identified in previous inspection reports.

Regulation 17 (1) (2) (a) (b) (c) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance).

The enforcement action we took:

We have issued warning notices to the provider and registered manager for this breach.