Belle Rose Nursing Home Limited

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Inspection report

12 Prince of Wales Road
Dorchester
Dorset
DT1 1PW

Tel: 01305265787

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

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

Belle Rose Nursing Home was registered for 12 people. There were 10 people living in the home at the time of our inspection. People had a variety of care and support needs related to their physical and mental health.

This unannounced inspection took place on 24 February 2018. At our last inspection in October 2016 we identified a breach of regulation. This breach was in respect of the governance of the home. At this inspection we checked to see if the provider had made the improvements necessary to meet the requirements of the regulation. We found that they had made improvements to the quality of care people received in line with the findings of the CQC and quality monitoring carried out by the statutory agencies.

There was a registered manager for the service. 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 were happy with their care and they were confident in the registered manager and staff team. They told us the staff were kind and we saw staff were cheerful and treated people and visitors with respect and kindness throughout our inspection. People also told us they saw health care professionals when necessary and were supported to maintain their health by staff. People's needs related to on going healthcare and health emergencies were met and recorded. People received their medicines as they were prescribed.

Staff were consistent in their knowledge of people's care needs and spoke with confidence about the personalised support people needed to meet these needs. They were committed to supporting people to live their life the way they chose to within a homely environment. They told us they felt supported in their roles and had taken training that provided them with the necessary knowledge and skills. There was a plan in place to provide staff with refresher training. They told us there were enough staff and we saw that people received care and support when they needed it.

People felt safe. They were protected from harm because staff understood the risks people faced and how to reduce these risks. Measures to reduce risk reflected the person's preferences. Staff knew how to identify and respond to abuse.

Where people had received end of life care in the home feedback from relatives was consistent in its acknowledgement of the kindness and compassion of the staff team in ensuring people's wishes and needs

were met.

People described the food as very good and there were systems in place to ensure people had enough to eat and drink. Where people changed their mind about what they wanted to eat they were offered alternatives.

People were engaged with activities that reflected their preferences, including individual and group activities both in the home and the local area.

Staff understood how people consented to the care they provided and encouraged people to make decisions about their lives. Care plans reflected that care was being delivered within the framework of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had been applied for when necessary.

There were systems in place to monitor and improve the oversight of the home. We found that recording around staff recruitment and training and support was not robust and we have made recommendations about this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People felt safe and there were enough staff to meet their needs. People were supported by staff who understood the risks they faced and spoke competently about how they reduced these risks. People received their medicines as prescribed.

Is the service effective?

Good

The service was effective. People who were able to consent to their care did so. Staff provided care in people's best interests when they could not consent. Deprivation of Liberty Safeguards (DoLS) had been applied for appropriately. People's needs had been assessed and they were cared for by staff who understood these needs. People had the food and drink they needed and they saw health professionals when they needed.

Is the service caring?

Good

The service was caring. People received compassionate and kind care. Staff communicated with people in a friendly and warm manner. They treated people with dignity and respect. People were listened to and chose how they lived their lives.

Is the service responsive?

Good

The service was responsive. People told us they were supported to live their life the way they chose to. People were confident they were listened to and knew how to complain if they felt it necessary.

People were cared for with compassion at the end of their lives.

Is the service well-led?

Good

The service was well led. People and staff had confidence in the management and spoke highly of the support they received. There were systems in place to monitor and improve quality including seeking the views of people in ways that suited them. Staff were committed to the ethos of the home and were able to share their views and contribute to developments.

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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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24 February 2018 and was unannounced. The inspection team was made up of one inspector.

Before the inspection we reviewed information we held about the service. This included notifications the home had sent us and information received from other parties. The provider had submitted a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also received feedback from local quality monitoring teams.

During our inspection we observed care practices, spoke with six people living in the home, four members of staff, and the registered manager. We also looked at three people's care records, and reviewed records relating to the running of the service. This included two staff records, rotas, health and safety records, quality monitoring audits and accident forms.

Good

Is the service safe?

Our findings

People told us they felt safe. One person told us: "I feel safe. They listen to my worries." People described the things staff did that made them feel safe; such as being available and ensuring security. They were confident they could tell someone if this changed.

There was information in the entrance hall and in the office about how to report any safeguarding concerns. This information contained contact details for local safeguarding teams. Staff had all received training in how to follow the safeguarding process and were able to describe how they would report suspected abuse. They were confident any concerns would be taken seriously and acted on. One member of staff told us: "I would make sure the person was safe. The residents come first." Another member of staff described how in some situations they would call the police first.

People were supported by staff who understood the risks they faced and valued their right to live full lives. This approach helped ensure equality was considered and people were protected from discrimination. Care plans related to risk management and reflected the importance of judgement free support and care and focussed on the outcome for the person. Risk assessments were in place and reflected individual need, such as to prevent poor nutrition and hydration, to protect skin from damage or reduce the risk of falls. Staff described the individualised responses to these risks, explaining how to approach and speak with people, what distractions worked best and how people's previous experiences impacted on how they took risks. Risks were managed creatively to reduce the impact on people's well-being; this was particularly important when people found staff support with care difficult.

Equipment owned or used by the registered provider, such hoists and stand aids, were suitably maintained. Effective systems were in place to ensure equipment was regularly serviced, and repaired as necessary. Work was being undertaken and agreed during our inspection to maintain and improve safety in the home. This was done with the needs of individual people and creative solutions were sought to promote their independence whilst ensuring the safety of everyone living and working in the home.

There were enough staff on duty to meet people's needs. People told us, and we observed that this was the case despite the registered manager covering a post and doing the cooking due to staff sickness. Staff had time to sit and chat with people and were able to respond quickly when people wanted assistance, often anticipating need before the person requested it. We spoke with the registered manager who explained that they were currently recruiting additional staff but sought to maintain a minimum level of staff to meet people's care needs and social needs. This promoted people's wellbeing. The service also employed cleaning, kitchen, and maintenance staff to help ensure the service ran effectively.

The service had a suitable recruitment procedure. Recruitment checks were in place and demonstrated that people employed had the satisfactory skills and knowledge needed to care for people. Staff files contained appropriate checks, such as two references and a Disclosure and Barring Service (DBS) check. We were, however, unable to locate photo identification for one member of staff. Whilst this represented a minimal risk as the member of staff had worked in the home previously and was known to the registered manager,

this identification is required by legislation to reduce the risks of inappropriate staff working with people who may be vulnerable.

We recommend the provider reviews the way staff records are held to promote effective oversight.

Staff received effective training in safety systems, processes and practices such as moving and handling, fire safety and infection control. Staff were clear on their responsibilities to ensure infection control. They had been successful in managing a number of complex infection control risks respectfully and unobtrusively.

Staff understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these internally and externally as necessary. Staff told us if they had concerns the registered manager would listen and take suitable action. Accident and incident records were all read by the registered manager and actions taken as necessary. These had included seeking medical assistance and specialist advice. Lessons were learned and shared amongst the staff team via discussion or team meetings and agreed measures put in place to reduce the likelihood of reoccurrence.

The service had safe arrangements for the ordering, storage and disposal of medicines. Staff responsible for the administration of medicines had undertaken training and had their competency assessed. The temperature of the room where medicines were stored was monitored and was within the acceptable range. Medicines that required stricter controls by law were stored correctly in a separate cupboard and records kept in line with relevant legislation. Refused medicines were kept securely and returned to the pharmacy. Medicine Administration Records (MAR) were completed and audited appropriately. Where people needed to take medicines in ways that suited their individual needs, this was managed safely. Appropriate professionals were involved in assessments and decisions to ensure this was legal and safe. People were supported to access their GP's and other consultants who prescribed and reviewed their medicines. Where necessary staff appropriately consulted with medical professionals to ensure types of medicines prescribed, and dosages were helping people with their health needs.

People's rooms, the kitchen and communal areas were kept clean and fresh throughout our inspection. Where decorative and essential maintenance works were undertaken, people were consulted and considered. For example, people had been asked for their views when a carpet had needed to be replaced.

Good

Is the service effective?

Our findings

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 decisions made on their behalf must be in their best interests and as least restrictive as possible. MCA assessments and best interest decisions were in place and had been completed in a way that reflected involvement of people who knew the person. These were in place for specific decisions such as whether staff should provide care when the person was not indicating consent. These records were not clearly ordered and it was possible that a MCA assessment had not always been undertaken for each best interests decision. The registered manger explained that the service would continue to work with Mental Capacity Act professionals to improve their practice in this area.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLs applications had been made where appropriate and where they had been granted conditions attached to them were being met.

There were systems in place to check if people living in the home had a Lasting Power of Attorney arrangement for health and welfare. This means they would have appointed people to help them make decisions or make decisions on their behalf. The registered manager understood this process but no one had these arrangements in place at the time of our inspection.

Most staff had received training in MCA and DoLS and demonstrated an understanding of the principles of the legislation. They spoke about providing the least restrictive care and provided well considered examples. Staff informed people of what they were doing and asked permission when appropriate before giving personal care. Where people could not tell staff with words that they consented, staff understood the individual ways the person communicated with body language and facial expressions. Staff supported people to make as many decisions as possible by considering when and how they were asked to make them.

Before moving into the service people had their needs assessed across a wide range of areas. This assessment process identified initial support needs and enabled the service to determine whether or not they could meet those needs. People were protected from discrimination on the grounds of their gender, race, sexuality, disability or age. These assessments were used to develop a care plan for the person so care was delivered in line with current legislation, standards and good practice guidance. The registered manager discussed research they had undertaken throughout the inspection which showed they sought to achieve good practice. Staff knew people well and could identify what mattered to them and what they wanted to achieve.

There was a call bell system that people could use to alert staff in an emergency and electronic safety systems were adapted to suit individual needs. For example if people found safety pendants reassuring,

these were provided to them. A person had tried using electronic communication with a relative but had chosen not to use this. At the time of our inspection no one was using assistive technology to support their care or preferences.

Staff had the appropriate skills, knowledge and experience to deliver effective care and support. New employees completed a comprehensive induction programme. This consisted of a mix of training and shadowing as well as an introduction to organisational values. The registered manager highlighted it was especially important to embed the home's ethos of dignity, respect and non-discriminatory support at this stage. One member of staff described starting to work at the home saying: "I can always ask anything." Another member of staff commented: "I have been able to get to know people." None of the staff currently employed had needed to take the Care Certificate but there was a system to provide this if necessary. The Care certificate is designed to help ensure care staff that are new to working in care have initial training that gives them an understanding of good working practice within the care sector.

Staff were able to access comprehensive training that enabled them to carry out their roles. For example, care staff received regular face to face training in fire safety, moving and handling and safeguarding. Some of the training was provided as e-learning and not all staff had kept up to date with the providers training refresher plan for this. We discussed the challenges to this with the registered manager and they identified approaches that may support their individual staff members. Training was also provided through informal coaching and team discussion although this was not recorded.

Staff told us they felt supported by their colleagues and the registered manager. They all commented on how accessible the registered manager was. One member of staff said: "I like my boss." Another member of staff said: "I feel very supported." This respect and care was reflected by the registered manager who told us: "I am proudest of my staff team." There was a system in place for staff to take part in regular supervision and appraisal sessions although this had not been recorded formally for over a year. Staff and the registered manager highlighted that this support was provided and there was evidence that staff were able to discuss concerns, highlight training needs and discuss their career.

We recommend the provider seek appropriate guidance on recording staff support and training to enable effective oversight and on going improvement.

People were involved in decisions about what they ate and drank. They all told us the food was either "excellent" or "very good". People were asked about what they liked to eat as part of their assessment process and this included any cultural or religious dietary needs. Choices were offered verbally and where people chose not to communicate due to their mental health staff used their knowledge of the person and observation to ensure they had what they wanted.

People were supported to have a balanced diet that supported their health and well-being. Some people had been identified as being at risk because they did not want to eat or drink enough. Food and fluid charts ensured people's intakes were monitored and their weight was regularly checked. Some people did not want to be weighed and also did not want to have other measurements taken to monitor their weight. Staff checked how clothing was fitting on these people and kept a record of this to identify any trends of weight gain or loss. Care plans contained guidance for staff on how to support people to eat enough and information about people's preferences. Where concerns were identified health professional input was sought.

Meals were appropriately spaced throughout the day and flexible to meet people's needs. People chose where they ate their meals and staff offered food regularly. People were able to take their time eating and

any prompting was done patiently and with kindness.

The kitchen was in the centre of the house and the smells of food being cooked encouraged happy anticipatory discussion amongst people sitting in the lounge. The kitchen was clean during our inspection and we saw that the fridge temperatures and cleaning were monitored.

People's day to day health needs were dealt with in conjunction with health care professionals. Records showed that people had regular contact from a range of health professionals such as: GP's, consultants, and chiropodists. Staff supported people to access these professionals compassionately. They understood the challenges that this posed to some people and had enabled people to receive health care that they had previously rejected.

Staff told us they worked well with each other and communication was good. One staff member said: "We are a good team here." Another member of staff highlighted that information was always handed over.

People told us they liked the physical environment. One person told us: "It is lovely here. I would not change a thing." Another person told us: "It isn't home but it is homely." The service was on two floors and there was a working lift in place. Handrails were in place to support people to move around independently with confidence. People had chosen coloured door decals providing a 'front door' to their rooms. One person told us "I like my room" Another person described how they chose to spend time with others in the communal lounge before retiring to their room. There was access to secure, level outdoor spaces with seating and planting that provided a pleasant environment. There was a quiet lounge so people were able to meet privately with visitors in areas other than their bedrooms. The registered manager acknowledged that some areas of the home would benefit from updating. We saw that they had a plan to undertake this work as they could.

Good

Is the service caring?

Our findings

People who were able to talk to us about their view of the service told us they were happy with the care they received and believed it was a safe environment. Comments from people included: "The carers are very good – they are very caring", "(Registered manager) is very kind. I can talk to her about anything.", "The staff have good manners they are caring."

Staff told us they enjoyed their work and liked spending time with people. They all expressed their motivation for their work being the people living in the home. One member of staff said: "They come first. It is all about the residents." Another member of staff told us: "It is all about making this home. It is about people living how they want to." Information about people's life histories was gathered and this information was available to staff in people's care plans. Staff understood these histories and used the knowledge to support their work.

On the day of the inspection there was a calm and welcoming atmosphere in the home. People moved around the home and garden as they wanted, one person went into town and another person welcomed a visitor. Staff interacted with people in a caring and compassionate manner. They demonstrated a concern for people's well-being and were gentle but assured in their support.

People were supported to maintain their independence because staff did not provide unnecessary help. One person set the tables for everyone at lunch time others followed their own routines undertaking day to day tasks in their own time and at their own pace.

Staff took time throughout the day to sit and talk with people in the lounge and visiting people in their rooms. Some conversations were light hearted and familiar and this was appreciated. Conversation and interaction was encouraged regularly. This was particularly evident with people who were at risk of isolating themselves. Staff were also quiet and attentive when people needed reassurance or were focussed on a task that mattered to them. Some people's communication had been impacted by their health and they no longer used words as their main means of communication. Staff took time to understand people and were able to describe how people communicated.

Staff respected people's privacy and dignity. Staff knocked on people's doors and waited before entering and did not share personal information about people inappropriately. Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. One person told us: "I really love getting into my chair and listening to my music. I wouldn't change a thing."

People's cultural and spiritual needs were respected. One person described how they were supported to attend church weekly. Care records indicated that others expressed their spirituality in a way that suited them. Staff encouraged people to receive visitors in a way that reflected their own wishes and cultural norms, including time spent with privacy. The support people received to stay in touch with people who mattered to them was specific to each individual. For some people this meant that relatives were contacted to help the person make decisions about their care. When staff felt they needed guidance about how to

support people they sought the input of those who knew them well.

People were encouraged to make decisions about their care, for example what they wished to wear, what they wanted to eat and how they wanted to spend their time. People wore clean clothes and appeared well cared for and staff supported them with their personal appearance.

Good

Is the service responsive?

Our findings

At our previous comprehensive inspection published in October 2016 we identified that people did not have access to adequate meaningful activities. At this inspection we found an activity co-ordinator had been appointed. They worked to support group activities and one to one activities. People told us staff spent time chatting with them and they enjoyed the activities provided by the activity coordinator. One person who was struggling to continue with their activities due to failing eye sight was being put in touch with an association supporting blind people and would have access to a club and listening books. People were also being supported to go out for walks and shopping although they told us they would like to go out more. People's care plans included information about how they enjoyed spending their time and this information was being developed. There were a range of puzzles and activities available in the lounge and staff described being able to use these with people. The activities coordinator was continuing to develop their role.

People were supported to live their lives the way they chose and staff respected these choices. One person had a fixed routine that they enjoyed and staff understood that this was necessary for the person's wellbeing. Where people could not communicate their preferences verbally relatives and health professionals had contributed to the care planning process. Staff described people's needs without judgement and emphasised people's individuality in all their discussion with us. Care plans were current and covered a range of areas including emotional well-being, mobility, communication and nutrition and hydration. They were individualised with information about people's likes and dislikes and clearly represented their views and wishes. Staff were aware of each individual's care plan, and told us care plans were informative and gave them the guidance they needed to care for people safely. When care plans had been updated it was clear what had changed. This meant staff and appropriate professionals would be able to monitor people's needs.

Communication needs were identified at assessment before people moved into the service. These were recorded in the care plan so staff had information about people's needs. The care plans were updated to reflect changes and new information. One person's verbal communication had been impacted by their health condition. Staff respected that the person did not use words unless they were indicating one specific wish. We saw they used this person's interest to encourage compassionate communication.
There was a system in place for receiving and investigating complaints. There was information about this available to all visitors and people by the front door. People confirmed they knew how to make a complaint and felt any concerns raised would be dealt with to their satisfaction. They told us they did not have any complaints. There were no on going complaints at the time of the inspection.

Where appropriate people had been spoken with about their wishes and choices for the end of their life. The registered manager had gathered good practice guidance and started to record information about people's wishes. The registered manager described how difficult this subject was to most of the people living in the home. They told us they created an environment where people were able to share their wishes when they chose to and that professionals were involved if appropriate. They explained how they were able to support staff and people when a person passed away by ensuring extra staff and being present themselves whenever possible. The home had received compliments from relatives of people who had died. These compliments

highlighted the kindness and compassion of staff.

Good

Is the service well-led?

Our findings

At our previous comprehensive inspection published in October 2016 there was a breach of regulation relating to governance because improvements identified as necessary in previous CQC reports had not been acted upon. At this inspection we found these improvements had been made and the registered manager was also working to meet actions identified during commissioner monitoring.

The registered manager, who was the owner of the home, spent time within the service so they were aware of day to day issues and knew all the people living there well. People reacted with warmth to them and this was reciprocated. The registered manager spoke highly of the whole staff team and explained they were all motivated to do the best for people. They told us this was what motivated them also, stating: "The people come first. They get what they need. They are happy."

Staff spoke with pride about their own work and that of their colleagues in securing good outcomes for people. All the staff emphasised the role of management in their confidence in the team. One member of staff said: "(Registered manager) knows everyone. We can talk about things. They don't just tell you." Another member of staff said that "the boss is like a mother" and explained they felt cared for and nurtured as a member of the team. . There was a culture of openness evident; records indicated that information was shared with significant others after incidents or near misses. Staff told us they would be confident to whistleblow if this was necessary. They were appreciative of the openness and availability of the registered manager to address any concerns.

The service had a clear management structure. The registered nurses were accountable when on shift. One nurse spoke highly of the knowledge held by the care staff and said they would always check their understanding with their colleagues. They all reinforced that they could make contact with the registered manager whenever it was necessary and were confident in the registered manager's skill and knowledge.

The registered persons had ensured all relevant legal requirements, including registration, safety and public health related obligations, and the submission of notifications had been complied with. The previous rating issued by CQC was displayed. The registered manager believed staff had a clear understanding of their roles and responsibilities and this was evident to us throughout the inspection. We identified that the provider retained an unnecessary registration and they agreed to apply to have this removed.

Records were stored securely. There were systems in place to ensure data security breaches were minimised and staff understood the importance of respecting confidentiality.

The registered manager had a quality assurance process that included audits and these were effective in identifying where improvements were necessary to ensure quality in all areas of the service. They audited a range of aspects of service delivery including: care plans, medicines, dignity and respect, infection control and health and safety. Their oversight had been effective in securing quality. For example work was being done on fire safety during our inspection following work identified in an audit and a carpet had been replaced following a review of infection control.

The approach to quality assurance also included asking relatives and professionals to contribute to an annual survey. This had not been successful in securing feedback. It is important to establish systems of feedback that work for each individual service. People were heard informally as more formal systems had not been successful. We saw that their views and preferences were used in improvement work.

The registered manager told us their relationships with other agencies were positive. Where appropriate the registered manager said they ensured suitable information, for example about potential safeguarding matters, was shared with relevant agencies.