Alo Care Ltd

Bellus Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 29 February 2017 and was announced. The inspection continued on 2 March 2017.

We carried out an announced comprehensive inspection of this service on 5 April and 6 April 2016. After that inspection we received concerns in relation to the care and support of people and management of the home. As a result we undertook another comprehensive inspection.

Bellus Lodge provides accommodation and personal care to people with learning disabilities and behaviour support needs. It is registered for up to six people. At the time of our inspection there were six people living there. There were two bedrooms on the ground floor and four bedrooms on the first floor. There was a main kitchen and open plan living and dining area. This led into an enclosed garden and patio area.

As a condition of registration the service must have 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. There had been changes in the management of the home immediately prior to this inspection. The manager registered with us no longer managed the carrying on the regulated activity.

Bellus Lodge was not always a safe place for people to live. Safeguarding systems and processes in place were not established and did not operate effectively to prevent potential abuse of people.

Risks were not always managed safely. Risk assessments were not always followed appropriately and several staff told us they had not read these. We found that injuries and marks were not always recorded or reported.

People were not always receiving care from staff that were competent, skilled and experienced. There was a risk that people were receiving care from staff who had not had training to meet the needs of people with learning disabilities and complex behaviour. People were being physically restrained and administered medicines by untrained staff. People received bruising following restraint by untrained staff. This left people at risk of unsafe care and treatment because staff did not have the appropriate training and knowledge to provide effective care.

Information regarding pre-employment checks was not available to us during the inspection.

People's rights were not always protected under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty they have been authorised by the local authority as being required to protect them from harm. Assessments had not been completed specific to the decision that needed to be

made around people's capacity. DoLS applications had been submitted to the local authority.

People were not always supported effectively in relation to their nutritional needs or continued health care. Plans and guidelines were not being followed by staff. Staff confirmed that menus did not always reflect people's food likes and dislikes. People were not always supported to access health care services appropriately.

Positive caring relationships were not always established between people who lived at Bellus Lodge and staff members working with them. We found that staff had not read people's files and did not know everyone they supported.

Staff at the Bellus Lodge did not always treat people with dignity and respect. Care and support was not always delivered privately. There were times where people were watched and observed for periods of time throughout the day. There was evidence of lack of interaction and choices for people at the service around how their care was to be delivered.

The service was not always responsive to people's health, social and recreational needs. Care plans and assessments were not always followed by staff. Daily recording was irregular and did not reflect each person each day. Staff were unable to look back on previous daily note entries or their colleagues as the on line system they used didn't allow this. This meant that staff and the provider could not be certain that each person's needs were being met on a daily basis.

Families and friends were not supported to express their views or get involved in decisions. Feedback surveys to people, relatives, friends and stakeholders had not been coordinated or sent out.

Bellus Lodge was not managed or lead well. Staff were able to give examples of when they had felt unsupported. Professional boundaries were not established and a positive culture was not embedded.

There were not effective systems in place to assess and monitor the quality of the service. Although some audits had been undertaken these had not been used to improve the quality of care for people and actions identified had not been followed up or completed.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had not informed the CQC of a number of significant events.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach under Health and Social Care Act 2008 (Registration) Regulations 2009 . The overall rating for this service is 'Inadequate' and the service is therefore placed into '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 time frame. 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.

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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough suitably trained staff deployed at the service to meet
people's needs and keep them safe.

People were not always safe because safeguarding systems and processes in place were not established and did not operate effectively to prevent potential abuse to people.

Staff were not aware of their roles and responsibilities in how to protect people.

People were not protected because safe recruitment practice was not being followed.

Medicines were not managed safely and were administered by untrained staff.

Is the service effective?

Inadequate

The service was not effective.

People were not always supported by staff that had the necessary skills and knowledge to meet their assessed needs.

Staff did not understand how to apply legislation that supported people to consent to treatment. Where restrictions were in place this was not always in line with appropriate guidelines.

People were not always supported to maintain healthy diets or follow professional's advice.

People were not always supported appropriately to have access to healthcare services.

Is the service caring?

Inadequate

The service was not always caring.

People were not supported by staff that made time for them.

People were not supported by staff that always used person centred approaches to deliver the care and support they provided.

Staff did not all have a good understanding of the people they cared for and supported them in decisions about how they liked to live their lives.

People were not always supported by staff who respected their privacy and dignity.

Is the service responsive?

Inadequate

The service was not responsive. Care files were not personalised. Outcomes and goals were not set or up to date and regularly reviewed.

People were supported by staff that did not always recognise and responded to their changing needs.

There were no active systems in place for people, relatives or professionals to feedback to the service.

Complaints had been made but inappropriate action or no action at all had been taken to address these.

People did not always have access to activities that were important and
relevant to them.

Is the service well-led?

Inadequate

The service was not well led.

Systems and processes to monitor safety and quality of care in place were ineffective and not robust.

Accurate and contemporaneous records were not always kept.

People received poor standards of care and staff told us they felt unsupported by the management.

A positive, open and empowering culture was not promoted or embedded at the home. Professional boundaries were not established due to a lack of good management and leadership.

Appropriate notifications were not sent to the CQC.

Bellus Lodge

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.

The inspection took place on 28 February and was announced. It continued on 2 March 2017. The provider was given 24 hours' notice of the inspection to ensure people were available to speak with us. The inspection was carried out by two inspectors on the first day of the inspection and three inspectors on the second day.

Before the inspection we reviewed the information we held about the service. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with one person and four relatives of people living in the home. We spoke with 11 care staff and reviewed six people's care and support records. We also looked at records related to the running of the home such as: policies, risk assessments, quality audits, incidents and complaint forms. We looked at four staff files, the recruitment process, training, supervision and appraisal records.

We spoke with a director and members of the management team. There had been changes in the management of the home immediately prior to this inspection. The manager registered with us no longer managed the carrying on the regulated activity.

Inadequate

Is the service safe?

Our findings

People were not supported safely and were not always protected from harassment, avoidable harm and abuse.

People were placed at risk when being physically restrained by staff. We looked at a sample of incident forms between September 2016 and March 2017 which indicated seven occasions where people had been physically restrained by staff who were not trained how to apply restraint techniques in a safe manner. On one occasion a person had sustained bruising to their arm during the restraint. On the second day of our inspection we observed one person being physically restrained by two members of staff using a technique that was not detailed in their behaviour management plan. One of the staff members applying this restraint had not received training.

A member of the management team confirmed that there was not always enough staff trained in physical restraint and when this occurred untrained staff would have to use the techniques and be directed by the staff trained in physical restraint. A staff member told us, "I am not trained in physical restraint but I have sometimes had to use it. I have been told by managers that I can use it if there is another trained staff member. I don't think it's right". This was not in line with national guidance prepared by the Department of Health; Positive and Proactive Care: reducing the need for restrictive interventions.

People did not always receive the medicines they were prescribed. A person had been without their prescribed medicine used to treat diabetes. The prescriber had advised that this medicine should be omitted for one week. However, this medicine had not been administered between October and December 2016. We looked at four people's medicine records. One person's Medication Administration Record (MAR) showed that their medicine had been administered but remained in the blister pack. There were also two entries stating that medicine had run out. However, this medicine remained in their blister pack. The assistant manager agreed that these people had not received their medicines as prescribed.

Medicines were not stored securely. We observed a staff member left the door to the room where medicines were stored unlocked and open whilst administering people's medicines.

Medicines were not administered safely. Staff told us that they had not received training in the administration of medicines but had administered people's medicines. A staff member who had confirmed that they had not received any administration of medicines training told us that they had been walking around with a person's medicine in their pocket. They told us that there was no guidelines regarding the administration of this medicine for staff to take out with them and that they were not aware of what the protocol was. This put people at risk of medicines being administered in an unsafe manner.

People did not receive appropriate care to keep them safe as staff were not aware of people's risk assessments. People had risk assessments explaining how staff should support them to reduce the risks. The majority of staff working during the inspection told us that they had not seen or read these. A number of incident forms showed that people were given a sedating medicine following a period of distressed

behaviour. This was contrary to their behaviour risk assessment and management plan which did not detail the administration of medicines within the post incident procedures. The administration of 'when required' medicines was only listed as a last resort if all proactive strategies for example restraint failed.

We found that only one person had a personal emergency evacuation plan in their file. The other five people did not have one in place. These plans detailed how people should be supported in the event of a fire.

There was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

A number of allegations of abuse had been made and were being investigated by the local authority. Following these allegations the provider had suspended a number of staff members. However, actions had not always reduced the risks of abuse. For example, serious allegations were made against one staff member. This staff member was deployed elsewhere within the organisation and there remained a potential for this staff member to have contact with vulnerable people.

Safeguarding systems and processes in place were not established and did not operate effectively to protect people from abuse. Allegations of abuse were not reported to the local authority as required. For example, A staff member had become aggressive towards another staff member during a shift threatening violence. These threats and aggression took place in front of people who lived at Bellus Lodge.

People and families did not always feel the home was safe. A family member told us, "I'm concerned that (name) has been bitten before by other people at the home." The person told us that they had been hurt by other people using the service and that they were, "nervous it might happen again but feel staff could keep me safe".

People were not protected from improper treatment. A person had been restrained in a manner that was not consistent with safe techniques or the person's plan of care. The person was prevented from exiting their room as staff held their bedroom door closed. This was disproportionate restraint and put the person at risk of avoidable harm and restricted them of their liberty of movement. Another person was verbally abused by a member of staff and threatened that if they did not remain in their room another person who lived at Bellus Lodge would be 'set on them'. We observed that two people's movement was restricted to keep them separate from each other. Neither person's risk assessment detailed this intervention.

Incidents were not reported appropriately to ensure people's safety and protect them from abuse. There were inadequacies with the incident reporting system. One person's relative told us they discovered their family member had a number of bruises on their body. On contacting the provider, the relative was supplied with an incident form which did not detail all of the bruises apparent on their family member's body. Two out of the three staff told us that they did not record injuries to people using a body map. There was a risk that injuries were not appropriately recorded which left people vulnerable.

We found that two electronic incident reports written by staff on line on 09 November and 08 December 2016 had been altered. The altered reports had removed the names of untrained staff and some events that had taken place during the incident. Only managers at head office had access to these reports.

Risk assessments for two people stated that their finances should be checked three times a day to ensure that balances were accurate and correct. We found that these risk assessments were not being followed.

Staff told us they felt the service was safe because the staff were good. Staff were able to tell us how they would recognise signs of abuse and who to report it to internally however; they were not clear who they could contact outside for example the local authority or CQC.

This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were not protected because safe recruitment processes were not followed. Information regarding pre-employment checks was not available to us during the inspection. It was not clear if new staff had received criminal records checks with the Disclosure and Baring Service (DBS). The DBS checks people's criminal record history and their suitability to work with vulnerable people. The manager did not know if the checks were in place. There was an indication in one person's file that indicated that they may be unsuitable for work with vulnerable people due to their conduct in their previous employement where they had been dismissed. No risk assessment had been carried out in relation to the employment of this staff member.

These were breaches to Regulation 19 (1) (2) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People at the home received a mixture of 1:1 and 2:1 staffing. We found that there was a regular use of agency staff. Rotas showed that the majority of time there were appropriate numbers of staff however; they were not always adequately trained or supported. The majority of staff told us there were enough staff to support the people but said that appropriately trained staff was a concern.

Inadequate

Is the service effective?

Our findings

People did not always receive effective care from staff who had the knowledge and skills they needed to deliver support based on best practice.

The services local core training record included; first aid, fire safety, communication, Mental Capacity Act and an introduction to learning disabilities as well as physical restraint and medicines. We identified that 27 out of 30 staff had not received fire safety training. 14 out of 30 staff had not had physical restraint training. 10 out of 30 staff had not received training in first aid and 16 out of 30 staff had not received training in communication.

A staff member told us they were the shift leader on 2 March 2017. The duties included coordinating the shift and being the first point of contact for the other staff working that shift. This staff member was new to care, had not had confirmation of successful completion of their induction and had not received physical restraint or medicines training. This staff member told us that they had not started the care certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. This showed that unqualified staff were accountable for shifts. Two other new staff said that they had completed their three month probation period but had not started the care certificate.

Staff did not receive appropriate support and supervision. Staff did not receive supervision as planned. Records which showed that out of 21 staff only five had received supervisions which all took place in October 2016. Staff told us they had not had a formal supervision since they started at the service. Three staff confirmed that they did not receive debriefs following incidents. This was contrary to people's behaviour support plans which stated that de-briefs would take place with both staff and people following incidents. De brief meetings are an opportunity for staff and people to reflect back on incidents, review actions taken and identify any learning. This meant that staff were left vulnerable and did not have the opportunity to discuss incidents through with management or gain from any learning.

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

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under MCA. The application procedures for this in care homes and hospital are called the Deprivation of Liberty Safeguards (DoLS).

All six people living in Bellus Lodge had a learning disability and had been assessed by the provider as

lacking capacity to consent to being accommodated at Bellus Lodge and the provider had submitted applications to deprive all six people of their liberty under the Deprivation of Liberty Safeguards. However capacity assessments were not completed nor best interest decisions recorded in relation to their care and treatment. A staff member said, "I have never seen capacity assessments here. Not seen any best interest decisions". A staff member said, "MCA says we have to look after people and give them what they want when they need it. Not done the training yet". The training record showed us that 16 out of 30 staff had not received training MCA training.

We found that all six people had holes in their bedroom doors which allowed observation of them from outside the room. No mental capacity assessments or best interest's assessments had been carried out in relation to the observation of the six people in their bedroom using these spy holes. We observed staff looking through the spyhole on one person's door on several occasions. There was a risk that peoples care and treatment was not provided in an appropriate manner as decisions had not been taken with due regard to the principles of the Mental Capacity Act 2005.

A member of staff told us one person received medicines in their drink without their knowledge. There was no MCA assessment in place for this or best interest decisions recorded. There was a risk that this person's care and treatment was not provided in an appropriate manner as this decision had not been taken with due regard to the principles of the Mental Capacity Act 2005.

People were not always supported appropriately with regards to their nutritional needs. One person had a plan to support healthy eating. Staff supplied the person with biscuits with chocolate spread and several bags of crisps between meals which was contrary to their plan. There were clear guidelines in this person's care plan to encourage healthy eating. A snack box had been introduced which kept one healthy and one unhealthy snack inside for the person to choose each day. We observed in the evening of day two of the inspection this person eating a large plate of chips with noodles for dinner. These decisions made by staff had not been in the best interest of the person.

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found that there was a two weekly menu and were told by staff that this was formulated by one of the managers at head office who did not involve the people living at Bellus in the creation. Staff told us alternative options are available to people should they not want what is on the menu. The menu was displayed on the people's notice board in very small text font. Staff told us that no one could really read this or understand it so they had to explain it to the people. We were told that pictorial menus were not used. A staff member told us, "I have e-mailed head office a number of people's food likes but these are not reflected on the menu". This did not demonstrate that people were able to make choices and decisions in the menu planning.

The provider did not work with healthcare professionals appropriately to ensure people received effective healthcare. Staff could not show us evidence that people had attended regular health appointments such as GP, dentist, opticians. We were told a person had an appointment booked following our inspection due to high blood sugars. A health professional told us that Bellus Lodge had been given a meal plan for a person on 18 October 2016. They told us that the person did not like this and that Bellus Lodge had informed them that they would be planning a meeting. However, this meeting is still to be arranged. Another health professional told us that they had been trying to work with the service in relation to epilepsy. They had requested that seizures be recorded and information shared to keep risk assessments and care plans reviewed and up to date. They told us communication can be quite poor and that mobile phones were never picked up. One person's relative had explained to staff in November 2016 that the person's medical

test would be due December 2016 and had asked a number of times for this to be arranged. The family member said that staff finally took the person on 24 February 2017.

Inadequate

Is the service caring?

Our findings

People's privacy and dignity was not always respected by staff. A staff member told us that when supporting people with personal care, "Privacy and dignity isn't always respected. Not many staff will cover private areas. I do. Some staff question why I do it". We observed a person receiving personal care with their bedroom door and curtains open. We observed a staff member say "Be a good boy" to a person. The person was sitting on the sofa using their tablet computer. The comment was not said in a mean or angry way but did not demonstrate respect. We observed a member of staff looking into a person's hole in their door. Afterwards they knocked, went in and asked the person if they wanted anything. This person would not have been aware the member of staff had looked through their hole. A person told us, "Some staff don't knock. Someone came barging in yesterday". This showed that staff did not always promote people's privacy and dignity when supporting them.

Positive caring relationships were not always established between people who lived at Bellus Lodge and staff members working with them. We found that the majority of staff working during the inspection had not read people's files and did not know everyone they supported. One staff member who had worked for three months said that they had only read one of the six people's care plans which had helped them build a relationship with the person. One person was receiving 2:1 support however we observed one of their staff members sat down and using their phone away from the person for approximately 3 hours. This staff member told us that they were new and had had no time to read people's files.

A person told us, "There are some staff that are different, I don't know them". A family member said, "Often staff there I don't know and aren't as smiley". We spoke with two agency staff who told us that they had not read any information about the people they were supporting. Throughout the inspection staff were seen often watching and observing the people. There was very little interaction between people and staff other than when incidents occurred or people asked for something. We were told that staff did not always support people using caring, respectful approaches. A staff member said, "Staff often argue about working with (name). Arguments have taken place in front of (name) about who is working with them".

A person talked with us about the choice and control they had in their life. They told us, "I'm allowed to sleep in at the weekends but in the week day care staff say no". They went onto say, "I don't like the farm because I don't like the animals. They've told me it's not fair on the boys if I don't go. They don't listen. I have to go".

Staff told us that they enjoyed working with the people. One staff member told us, "I support (name) positively. I do sensory baths. Bubbles, lights and water, they love it. I have a good relationship with them". Another staff member said, "The best thing is building relationships with people who live here. Making people laugh is rewarding".

We observed one nice interaction between a person and their staff member who was smiling with the person, clapping, laughing and using signs to communicate with them. The person was spinning and enjoying themselves. We saw the staff member say, "Very very good" and "That was good dancing". This was

encouraging and the person responded by smiling and laughing.

Inadequate

Is the service responsive?

Our findings

Accurate and complete records of the support and care provided to people were not kept and staff did not have access to information to enable them to be responsive to people's needs. Daily notes were completed on smart phones via an on line system. Daily notes are a way of staff recording daily activities which had taken place, significant events. Staff told us that they could not view these notes once they had been completed or refer back to colleague's notes. Only managers at head office could access these. We reviewed people's daily records for the month prior to our inspection. These records were not always completed for all people. This meant that staff could not always respond to people's needs as they were unaware of what needs had been met by other staff and what activities and events had taken place during other shifts.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were not always supported to participate in activities. Staff told us that people weren't always allowed to leave the home because staff were not adequately trained. A family member said that their loved one preferred going out on their own (not group activities) but that recently it had not been as often. The family member told us, "They kept saying they would give me an activities list but this hasn't happened". Another person had become distressed when they were prevented from doing an activity they valued. During the inspection we were told that there were insufficient trained staff to enable people to participate in activities.

Information was not provided to people in a form that was accessible to them. One person's care file said that they used visual timetables, story boards and timer clocks to support them structure their day. We asked staff if we could see these. Staff were unable to locate them. We read that people found knowing the date helped them plan and count down for certain activities. We noted on 2 March 2017 that the weather and date were written on the people's notice board however, the date showing was 6 February 2017. This showed us that people were not being supported in a way that met their identified needs.

People's support plans were not always personalised. People's care files did not contain initial needs assessments which meant there was no foundation for care and behaviour support plans to be centred around. People had objectives set in their care plans which detailed how to support them and their preferences however, no goals or targets had been set in order to enable them to gain new skills and promote independence. One person was moving from Bellus Lodge. This move was not reflected in their care plan. Transition plans had not been completed to demonstrate how the person had been involved in this process. A health professional told us, "Lots of issues regarding keeping risk assessments and care plans up to date and reviewed. Chased several times but not done"..

Communication with those significant to people was inadequate. A family member said, "If there are major incidents they will let me know but communication is not good". Another family member told us, "We had a review arranged end of November 2016. I'd had a lot of issues about what my loved one was eating. One of the managers kept changing the dates and then rung and said they were sick. I asked for the review over the phone in the end and planned actions needed. We then had a review with the local authority which resulted

in action being taken.

Systems in place to report concerns and complaints were not effective and staff told us that management did not respond to these appropriately. A staff member told us, "I have complained a number of times before. Not followed up by management". This staff member said, "During a new starters shadow shift a staff member was unprofessional, swearing, shouting and wheel spinning out of a car park. (name) was in the car. I contacted the manager to complain. The manager changed the person's timetable and cancelled activities instead of sending the staff member home". Other staff told us that they had complained before via the online system but nothing had been done about them. We reviewed 10 complaint forms which had been completed by staff. Steps taken to resolve these had not been recorded on the forms. This demonstrated that these concerns were not acted upon appropriately which resulted in a person's not being able to have their social needs met that day.

At our last inspection we recommended that the service seek advice and guidance from a reputable source about supporting families and friends to express their views and involving them in decisions about the care, treatment and support of people. We found that Bellus Lodge were still not consistently supporting families and friends to express their views or get involved in decisions. Feedback surveys to people, relatives, friends and stakeholders had not been coordinated or sent out. A family member told us, "I would like them to tell me things". Another relative said, "Communication is not good. I don't get any regular updates and I always have to chase".

On day two of our inspection we saw one person being supported to go into town to get their nails done and go to the coffee shop. The person was excited about this. Upon the person's return we asked them if they had enjoyed themselves to which they replied yes.

Inadequate

Is the service well-led?

Our findings

The provider had introduced changes in the management of the service immediately prior to the inspection and in response to a number of concerns relating to the quality and safety of the service. A condition for registration required the provider to appoint a registered manager. While our register indicated that there was a registered manager in place, this person was no longer working for the organisation. 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. In response to widespread concerns regarding the management of the home the provider had commissioned a management consultancy and an interim manager was appointed.

The service had not benefited from accessible and visible leadership. Staff told us that they had rarely seen the registered manager. The assistant manager said, "The registered manager was supportive at first. Been trying to contact them for six weeks but no reply. My probation for assistant manager role was up on 1 February 2017 but still don't know if I'm successful. I have never had a contract or job description. My duties, responsibilities and accountabilities are not clear".

Systems and processes in place to monitor the safety and quality of care were ineffective and had not identified the concerns we found during our inspection. There was a lack of good, consistent leadership in the home. This resulted in people receiving poor standards of care and staff feeling unsupported. The registered manager and provider had failed to understand how to properly monitor the quality of services provided for people. This had contributed significantly to the failings identified during the inspection.

There was a lack of effective audits to identify gaps and trends to drive improvement and keep people safe. The medicines audit dated 3 October 2016 did not identify whether medicine room temperatures had been checked or recorded. There was a room temperature log in the medicines room which should have recorded temperatures in the morning, afternoon and night time. We found that the log sheet for February 2017 had only been completed in the afternoon on the 1st, morning and afternoon on the 6th, afternoon on the 21st and afternoon on the 24th.

There was a fire alarm test log which stated fire alarm tests should be carried out and recorded weekly and evacuations should be carried out and recorded monthly. We found that tests were only completed once a month in June, August, September and October 2016 and February 2017. We found no evidence of fire alarm tests or evacuations carried out in July, November, December 2016 or January 2017. The health and safety audit dated 3 October 2016 showed that a fire drill had been carried out for night staff between July and October 2016 and that the fire log was up to date. This is contrary to our evidence and meant that audits were not accurate and as a result did not identify improvement areas.

Actions identified from quality monitoring were not implemented and improvements had not been made. For example, the quality assurance audit completed identified that six monthly appraisals had not been completed and were not on file. We found that staff had still not received their appraisals at the time of the

inspection. Auditing found that records were incomplete, this remained an issue for the service as little action had been taken to address this.

On 2 March 2017 we identified that a fire extinguisher was missing from its container on the first floor. The manager was unaware that this was missing when we mentioned it to them, they noted it on paper and said that they would look into it. This showed us that the oversight of health and safety was lacking.

These were breaches to Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We had not received any notifications of other incidents from Bellus Lodge since it registered with us. We found that there were a number of notifiable incidents which included injury, allegations of abuse and incidents reported to or investigated by the police.

This was a breach of Regulation 18 (2) Notification of other incidents Health and Social Care Act 2008 (Registration) Regulations 2009

Seven staff members told us that they did not receive the appropriate support necessary to enable them to carry out the duties they were employed to perform. During day two (2 March 2017) of our inspection a staff member told us that on the weekend on 25/02/2017 he was punched in the face by a person living at Bellus Lodge. This caused the staff members nose to be cut by their glasses and feel faint. The staff member said that no support was provided and they were not able to take any time off or any hours of annual leave to recover. The staff member explained that they were told to finish the shift by the on call manager. We were told about another incident the week before our inspection where a person required PRN as they were in pain. We were told that it took on call 15 minutes to get back to the home and authorise the administration. A staff member said, "It was unfair on (name) that they had to be in that pain". A staff member said, "I had an incident with (name). They head banged me. I had a bad head the next day. On call told me I had to work. Not supportive". This did not demonstrate good management or supportive leadership.

The assistant manager said, "I'm getting no feedback or information from head office about situations or incidents. A local authority contacted me to discuss an incident but I did not know any information. This made me look as if I didn't know what I was doing". A staff member told us, "Senior management don't lead or manage well. They make decisions based on assumptions".

A positive, open and empowering culture was neither promoted nor embedded at Bellus Lodge. A staff member told us, "It's all about who you are liked by which is not right". Another staff member told us, "Team morale is good until you ask staff to do certain things. Staff often dictate what they will or won't do and not what they are paid to do" They went onto say, "I've witnessed staff coming in and looking on the board and saying yes, no, no, no not doing that. There are no professional boundaries". Another staff member explained, "Professional boundaries not clear. Some staff cross the line". The assistant manager said, ""There are no professional boundaries in place. I feel I can't implement changes or make decisions because I have no job description or clear responsibilities".

A staff member told us, "The assistant manager is very good and will represent us".

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the commission of other incidents relating to injury, allegations of abuse and investigations involving the police.

The enforcement action we took:

We propose to vary Condition 2 which specifies the locations where you are authorised to carry on the regulated activity Accommodation for persons who require nursing or personal care so you are no longer authorised to carry on this regulated activity from the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not protected as the provider did not act in accordance with legal requirements of the Mental Capacity Act 2005.

The enforcement action we took:

We propose to vary Condition 2 which specifies the locations where you are authorised to carry on the regulated activity Accommodation for persons who require nursing or personal care so you are no longer authorised to carry on this regulated activity from the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not supported in a safe way. People were not always protected from the risk of harm and abuse because persons providing care did not have the adequate skills to provide care safely.

The enforcement action we took:

We propose to vary Condition 2 which specifies the locations where you are authorised to carry on the regulated activity Accommodation for persons who require nursing or personal care so you are no longer authorised to carry on this regulated activity from the location.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment. Safeguarding systems in place were not fully established and ineffective. The provider did not ensure that peoples liberty of movement was respected. Staff were inadequately trained in the use of physical restraint.

The enforcement action we took:

We propose to vary Condition 2 which specifies the locations where you are authorised to carry on the regulated activity Accommodation for persons who require nursing or personal care so you are no longer authorised to carry on this regulated activity from the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not in place to ensure the safe running of the service.

The enforcement action we took:

We propose to vary Condition 2 which specifies the locations where you are authorised to carry on the regulated activity Accommodation for persons who require nursing or personal care so you are no longer authorised to carry on this regulated activity from the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that recruitment information was available in respect of pre-employment checks of staff suitability. Recruitment processes did not operate effectively.

The enforcement action we took:

We propose to vary Condition 2 which specifies the locations where you are authorised to carry on the regulated activity Accommodation for persons who require nursing or personal care so you are no longer authorised to carry on this regulated activity from the location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were always enough suitably qualified and competent staff to deliver safe care to people.

The provider did not ensure appropriate support, training, supervision and appraisal opportunities were available to staff.

The enforcement action we took:

We propose to vary Condition 2 which specifies the locations where you are authorised to carry on the regulated activity Accommodation for persons who require nursing or personal care so you are no longer authorised to carry on this regulated activity from the location.