Four Seasons Health Care (England) Limited

Belle Vue Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was unannounced and took place on 13 December 2016. The inspection started at 06:40 am to allow us to meet with the night staff, and attend a morning staff handover.

Belle Vue Care Home is a purpose built care home registered to provide care for up to 52 people. On the day of the inspection there were 38 people living there. The home is set over three floors, with people receiving general nursing care on the ground floor and a locked unit for people living with dementia and mental ill health 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 but not exclusively older people.

Belle Vue Care Home was last inspected on 18 July 2016. The home was rated as Inadequate and placed in 'special measures' due to concerns we identified. These included concerns from the preceding inspection of June 2015 which had not been addressed. Many of these issues were related substantially to the first floor dementia care unit. We identified concerns over people's safety including unsafe practice with medicines administration, safety of the premises, risk assessments, staffing levels, management and governance of the home, and lack of caring and respect for people's dignity. Following the inspection we issued the registered manager and provider with three warning notices in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment), Regulation 10 (Dignity and Respect) and 17 (Good Governance). We later met with the provider and management team to review progress being made. The management team have sent us a weekly progress report and action plan. The local Authority business and quality improvement team have been involved with supporting the service make improvements.

This inspection was a focussed inspection carried out to ensure the provider and management team had taken sufficient action to meet the warning notice issued in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment). We will look at the actions taken to meet the other warning notices at the next inspection. The ratings from the comprehensive inspection of 18 July 2016 have not been changed as a result of this inspection, but will be reviewed at a full comprehensive inspection carried out to review overall progress being made. This will be undertaken within six months of the service going into 'special measures'.

We found that improvements had been made, and although some areas of progress were still needed, people's safety had improved. People and their relatives told us they felt safe at the home, and that the home had improved in recent weeks and months.

The home had a registered manager, although they were not working at the home at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was under direct oversight of a management team

from Four Seasons Healthcare (England) Limited, with an interim manager in post providing day to day cover.

People received safe care because risks to their health and well-being were regularly assessed, and risks reduced wherever possible. We saw people had received updated risk assessments in relation to pressure relief, falls, moving and positioning and nutrition. Actions had been taken to reduce risks, for example by referral to specialist agencies to provide advice on swallowing or pressure ulcer management. We identified some people were living with long term health conditions that were subject to a potential sudden deterioration. Some people did not have protocols for staff to advise them on actions to take or how to monitor the person in the case of a sudden deterioration in their condition. The interim manager agreed to ensure these were written within 48 hours of the inspection.

People befitted from living in an environment that was regularly assessed and actions taken to minimise risks. This included water temperature regulation, maintenance of equipment and window opening restriction. At the inspection we saw changes were being made to the fire management systems, including to fire doors. Following the inspection we contacted the local fire and rescue service for their specialist advice on the work being undertaken.

Learning took place to reduce the risk of re-occurrences of incidents and accidents, and systems to do this were being made more robust following a recent audit. Following the inspection of July 2016 where we had identified concerns over people's safety and vulnerability the service had taken action. Some people using the service who had presented risks to themselves or others were moved to other services more suited to their needs and some very frail people were moved to the ground floor general nursing care area. People's family members told this had impacted significantly on people's well-being, and they were no longer showing signs of anxiety. The dementia care floor was much calmer and more settled. People were experiencing more organised activity as a way of preventing the risks of social isolation and frustration, which had helped with providing the calmer atmosphere. People told us the staff were happier.

People received their medicines safely and as they had been prescribed. One incident where this may not have happened was under investigation, as it was not clear whether this was a recording or practice issue. Nursing staff were regularly assessed to ensure they had maintained their competence to give people medicines safely, including through medical devices.

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, although significant improvements had been made since the last inspection.

People received safe care because risks to their health and well-being were regularly assessed, and risks reduced wherever possible. Learning took place to reduce the risk of re-occurrences of incidents and accidents, and systems to do this were being made more robust.

People who experienced distressed or risky behaviours were receiving additional support. This helped reduce risks to themselves and others.

People received their medicines safely and as they had been prescribed. One incident where this may not have happened was under investigation.

People lived in an environment that was safe because regular checks were carried out. The home had an action plan to ensure areas needing development were attended to. We asked the fire authority for specialist advice in this area to help us monitor the actions the home was taking.

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, and in particular to look at actions taken by the provider in relation to the warning notices issued for Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment) following the inspection of 18 July 2016.

This inspection took place on 13 December 2016 and was carried out by one adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, namely care homes for older people.

We looked at the information we held about the home before the inspection visit, including the inspection history, previous reports and the action plans sent to us by the provider.

On this inspection the registered manager was not available. We spoke with the interim manager for the home, who was also a regional manager for Four Seasons Healthcare (England) Limited. Also in attendance were the resident experience care specialist and a registered mental nurse who had been working at the home supporting the staff team. We spoke with three people receiving a service, ten staff members, four registered nurses and eight visitors. We looked at areas of the building, and sampled policies and procedures.

We also looked at six people's care plans, risk assessments, minutes of meetings, sampled policies and procedures, and audits. We discussed the home's action plans and progress being made with regard to providing safe care and treatment.

Requires Improvement

Is the service safe?

Our findings

On the inspection of 18 July 2016 we identified concerns over people's safety. People were not being protected from risks associated with their care and the environment was not safe. We issued the provider and registered manager with a warning notice in relation to Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 – (Safe Care and Treatment). We also issued the service with a requirement in relation to the breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 with regard to the unsafe management of medicines. This was not included within the warning notice because immediate action was taken by the home at the time of the inspection to mitigate the risks.

On this inspection we looked to see what changes had been made and how risks to people were being managed and reduced. We found that there had been improvements to people's safety. Risks to people were being managed and mitigated and care and treatment was being provided in a safe way, although some areas still needed additional development.

People told us they felt they or their relations were safe. People and relatives told us there had been improvements. For example one person told us they felt very well looked after and safe. They said "They'll always lift me up and carry things for me….sometimes too much so" (meaning she felt pampered).Staff told us the changes had been "A breath of fresh air" and the home was "much calmer upstairs now – residents are much happier."

People told us their experiences of care were improved. However we found some care plans did not contain detailed action plans for the management of long term health conditions that presented risks to people's well-being. For example, one person at the home had a health condition which meant they could have seizures. The person had been prescribed an emergency medicine to be given during what was described as a 'prolonged' seizure. There was no guidance for staff as to what this meant or what form the person's seizure activity took. No guidance was in their plan on when to call for additional medical or paramedic support. This was believed to have been a long standing prescription and staff told us the person had not been known to have a seizure in recent years. Staff we spoke with were clear about the actions they would take to manage and mitigate risks to this person. However, this may not be the case for agency staff, who were being used to support gaps on the staffing rota and who did not have this information available to them. Another person had asthma and an associated long term lung condition. Good practice would be that the person had an asthma management plan to alert staff to when the person's condition might be deteriorating. This might include for example an increased use of 'reliever' medicines, and the actions to take at each stage. This would be based on the individual person's experience of asthma. The interim manager took immediate action to ensure these plans were developed.

Assessed risks to people were mitigated wherever possible. Each person had been assessed for risks from poor nutrition and hydration, pressure area damage, falls, mobility and moving and positioning needs. Additional risks such as from risky or distressed behaviours, swallowing difficulties and choking, or personal vulnerability were subject to individual risk assessments and control measures to help reduce any risks to

the person or others. We saw these measures had been put into place. For example one person had been assessed as being at risk of poor nutrition, in part due to difficulties with swallowing. This had led to a decrease in weight. The person had been referred to the dietician and speech and language team, who had given advice on textures of food to help the person with their swallowing and advice on supportive positioning. The dieticians had prescribed supplements to boost the person's nutritional intake. The person's weight had increased.

Information about special diets was available in the home and had been shared with the kitchen staff to help reduce risks. The chef told us they were clear about the differing textures of food people needed to help support them with swallowing difficulties, for example fork mashable or pureed textures. The home had a new chef who was working on improving the quality and presentation of meals to encourage people to eat. We observed a staff member supporting a person to eat. This was done sensitively, at a safe pace and with encouragement for the person to eat independently. When the person did not do this the staff member supported them, and praised them for eating with support. The person expressed pleasure in the food they were eating. We received positive feedback about improvements to the food, which was tempting people to eat better, and maintain their health.

Another person had a pressure ulcer on their heel. Their care plan contained detailed information about how the person was to be supported to reduce pressure damage. This included the specification of equipment provided to relieve pressure. Regular audits were carried out to ensure this was adjusted to the correct weight for the person to ensure they were working effectively. The wound had been assessed by the tissue viability service and new dressings prescribed to aid healing. We spoke with a registered nurse on duty about the wound care. They were aware of the new dressings and when the dressings were due to be changed. They told us about recent training updates they had received in prevention and care of pressure areas to maintain their competency. The person's ulcer was said to be improving. The nurse told us the home's camera was not working so they had been unable to photograph the wounds progress recently. The acting manager told us this was being addressed but in the short term the nursing team could use a company owned tablet computer to do so.

On the inspection of 18 July 2016 we identified people who presented risks to others were not supported well, or assisted to channel their frustration in positive ways. Staff did not have clear guidance on how to manage risks people presented. The increased management oversight since that inspection ensured incidents were assessed. This helped to determine if there was a pattern or actions could be taken to reduce the risks of a re-occurrence. For example, at the last inspection concerns were identified about the vulnerability of physically frail people in the dementia care unit. Incidents had occurred where people's safety and well-being had been compromised. Action had been taken to move some frail people down to the general nursing care floor. A relative told us of the impact this had on their relation. They told us the person had been "distressed up there as the male dementia patients would wander into her room…try and mess up everything, her bedding pulled". Care had been taken by the home to move the person to an identical room on the ground floor to minimise any anxiety for the person about their room change. The relative said they had photographs of the person before and after the move and said the change in them was visible –"all the anxiety had gone".

At the last inspection we had identified risks to people's safety because staff did not understand how to engage or occupy people with distressed behaviour. This had led to high levels of frustration amongst people being supported, leading to a number of incidents of risky behaviours. On this inspection we saw developments were under way to help ensure people were being protected from the risks associated with social isolation or frustration due to lack of activity or positive stimulation. Several people or their visitors told us about the positive impact the activities co-ordinator had made to people's lives. One told us "He

should be here all the time. He talks to everyone… it doesn't matter if they have dementia – he talks to them." We saw people playing games on the dementia unit. This was a positive experience for the people involved, generating much laughter. Where people did express distressed or risky behaviours staff had clearer guidance on how to manage these behaviours, including where the person needed physical support. A staff member told us "Now we know how to support people – I didn't know before".

Risks to people were reduced because learning took place from incidents, accidents or from other information gained. The home had a system for the regular evaluation and analysis of all falls, accidents and incidents, including incidents between people living at the home. The service had recently audited the system in use and found there were inconsistencies in the way information had been provided or assessed. This had meant for some areas it was not possible to follow the course of an internal investigation easily. An action plan was being drawn up to remedy this, including clearer tracking, the development of a safeguarding matrix and clear information in planned care planning training on the importance of tracking incidents. As a result of some incidents it had been identified that some people presented distressed or risky behaviours at particular times. This had led to these people receiving one to one support at times of high risk to themselves or others. We held discussion with the home's management on how to use this time as a positive support for people rather than just to maintain safety.

People were safe because staff had information available to help them in an emergency. Personal fire evacuation plans were in place for people, which would help staff understand the individual support people would need in the case of a fire. Agency nursing staff received a clear handover about people's needs and any particular risks associated with their care. Staff had access to senior management by phone for advice and telephone numbers had been given to staff to enable them to contact management at any time. The management team told us they had ensured there was a presence in the home over weekends to help staff feel supported, monitor the service and help keep people safe.

People's medicines were being stored and administered safely. We looked at the medicines management systems with two registered nurses, and reviewed the recording systems in use. People were given their medicines with an appropriate explanation and time to take them at their own pace. Some people received their medicines covertly, concealed in food. This was because they refused to take them, lacked capacity to make the decision and their GP considered these were essential for their well-being. The person had been assessed as not being able to understand the importance of the medicines, what they were for or what the implications were of not having taken them. The decision to give the medicines covertly had been made by people involved with the person's care, GP, Community psychiatric nurse and their close relatives as being in their 'best interests'.

We identified on the medicine administration records or MAR that one person had potentially not received their medicines as prescribed. The interim manager was asked to review this incident to see if this was a recording or practice error and notify relevant bodies as appropriate. This related to asthma inhalers which were prescribed to be taken twice a day. One inhaler had been prescribed for 'as required' use while the other was needed for regular administration to prevent asthma symptoms. The person's MAR had been marked to indicate the inhaler which needed to be taken regularly had not been needed for a four day period. Following the four days the person's file noted they were wheezing, and they needed to use their 'reliever' inhaler. We spoke with a registered nurse on the floor where the person was living. They were clear about the different types of inhaler in use and the need for one to be given regularly. Prescribing guidance was clearly marked on the administration records, and the medicine had been given correctly since that time. Information was available in the person's care plan on how these medicines should be used.

Nursing staff told us how they gave people their medicines. Medicines were stored safely in locked clinical

rooms on each floor and were taken around the home in locked trolleys. There was a refrigerator in each clinical room for medicines that needed to be kept cool. The temperatures on these were recorded regularly. The home had clear records to show the medicines people had taken. Records in relation to the amount of medicines held balanced correctly, including medicines that required additional security due to their strength or effects. Regular audits were carried out, and staff training and nursing medication competency assessments were regularly undertaken to ensure they were following safe practice in administration. Nursing staff told us they were up to date with syringe driver training, which meant they were competent to support the delivery of strong pain relieving medicines through a medical device. This could be used in end of life care to ensure people had consistent pain relief.

Protocols were in place for "as required" medicines, which gave information to staff about when these should be given, for example for pain relief. Where people's ability to communicate verbally was limited information was recorded as to how the individual person might express pain or discomfort that might indicate they would benefit from pain relief. This included the Abbey pain assessment tool. The organisation had as a policy they did not deal with homely or 'over the counter' remedies, such as simple linctus or indigestion remedies. If a person was not prescribed medicine for this the home would contact the person's GP to have this prescribed. This meant this would not be available for people in a hurry, and the interim manager agreed to look at this. Some advanced prescribing was in place for people nearing the end of their life. Medicines had been provided to the home in 'just in case bags' This helped ensure that where a person was at the end of their life medicine was immediately available to deal with any trouble symptoms such as pain or excessive secretions.

People were supported to live in a safe environment. Environmental risks were assessed on a room by room basis and these covered people's individual safety in the home as well as cleanliness of furnishings and odour control. We toured the environment with the acting manager, looking at areas of maintenance, infection control and safety. Odour control was improved since the last inspection, in particular in the dementia unit, although some specific areas were identified as still presenting issues. Some toilet frames were identified as being rusty and so could not be kept clean and hygienic, and these were immediately replaced with others that had already been ordered. Window restrictors had been repaired, to ensure people could not fall from windows above the ground floor. We spoke with the homes maintenance person about the schedules, audits and tests they carried out, which included testing and risk management of areas such as Legionella bacteria and asbestos. Regular fire testing was in place, and equipment was maintained under servicing contracts. Improvements and tidying had taken place in the garden area, and we saw one person was taken outside to sit in this area in a wheelchair during the inspection. Safety documentation was available for chemicals in use and cleaning materials were locked away.

The interim manager showed us an audit tool for infection control which they were due to implement. There were no identified infection control risks at the home. We saw staff had access to protective equipment when supporting people or providing personal care. Food safety in the kitchen had been rated as five out of five at an inspection in 2016 by the Environmental Health department.

The home had also been subject to an environmental assessment by an internal team from Four Seasons. This had led to a list of works to be carried out. For example, we identified during the tour of the premises there were issues with the home's laundry which meant it was not possible to achieve a separation between clean and dirty linens. This is important for achieving effective infection control. This had been already identified and costed out by the organisation as work to be completed on an action plan. A fire precautions audit had been carried out and work was under way to make improvements to fire doors and fit new locks to doors. We discussed these with the interim manager in terms of their suitability for people with dementia. Following the inspection we sought the advice of the Fire Authority in relation to the work being undertaken

on the fire precautions to ensure that timescales for action to manage risks were satisfactory.