Belle Vue Healthcare Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We inspected Bellevue Healthcare Limited on11 May 2016. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting. The inspection was completed because we had received a large number of concerns about the safety of the staffing levels at the home.

At the last inspection completed in April 2016 we judged the home to be rated as inadequate and found multiple breaches. More concerns had been raised over the intervening weeks so we visited to ensure people were not at an increased risk of harm.

Bellevue Healthcare Limited is registered to provide care and support to 102 people. At the time of our inspection there were 60 people using the service and 91 staff employed. There were three units at the service which provided care and support to people living with a dementia, people who required nursing care and young adults living with a physical disability.

Following the last inspection we had identified that the registered provider was failing to notify us about occasions when people who used the service had sustained serious injuries or died. We informed the registered provider this was a breach of the Care Quality Commission (Registration) regulations 2009. Subsequently they started to send in notifications and we identified occasions when people had died unexpectedly or been injured. We were concerned that the information indicated that the home may have neglected people's care and treatment needs and that the registered provider failed to understand the requirements of the regulations.

We found that the risks around ensuring people received safe care and treatment had not increased. People were not placed at any greater risks from staff failing to administer medication in line with their prescriptions. People were receiving adequate food and fluid. When people lost weight, we found staff were still failing to ensure referrals to dieticians were consistently made.

Bed rails were checked on a regular basis. However, there was no guidance available for this which meant we could not be sure what checks were being carried out.

At the last inspection we raised that people's dignity was compromised because staff undertook personal care with their bedroom door open. Staff also did not consider people's dignity when they sleeping and the custom and practice was to leave their doors open irrespective of whether they were in a compromising position or not fully dressed. We found the registered provider interpreted this feedback as the need to close all of the bedrooms doors and disregard people's choices or needs.

The registered provider had completed falls risk assessments but had not used this information to inform the action they should take. Thus, no falls monitoring systems such as pressure pads and motion alarms had been put in place for people who might be unsafe attempting to walk about in their room. We found they failed to understand how these risks could be reduced.

We found that the registered provider had started to collate all of the information about injuries people had sustained but was yet to complete an analysis of this information.

Bellevue Healthcare Limited had been registered with the commission since 2001. A registered manager was in place until 2014 when the registered manager retired. There had been three managers since then however none applied to become registered manager. At the time of inspection, one of the registered providers told us they were in the process of applying to become 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.

Not having a registered manager is a breach of the provider's registration conditions and we are dealing this matter with outside of the inspection process.

We found the provider was breaching eleven of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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.

We found that the risks around ensuring people received safe care and treatment had not increased.

People were receiving adequate food and fluid. However staff continued to fail to always identify when referrals needed to be made dieticians because people had lost weight.

Bed rails were checked on a regular basis. However, there was no guidance available for this which meant we could not be sure what checks were being carried out.

Bellevue Healthcare Limited

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 checked 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.

Four adult social care inspectors completed the inspection on 11 May 2016.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also spoke with the responsible commissioning office from the local authority commissioning team about the service.

During the inspection we spoke with eight people who used the service. We looked at the written feedback relatives had sent to us. We also spoke with two of the directors, the clinical lead, two nurses, two senior carers, six care staff and the administrator.

We spent time with people in the communal areas and observed how staff interacted and supported individuals. We looked at six care records, medicine administration records and weight monitoring records, staff rotas, falls prevention polices and accident/incidents analysis.

We looked around the service and went into some people's bedrooms (with their permission), some of the bathrooms and the communal areas.

Inadequate

Is the service safe?

Our findings

Following the last inspection we had identified that the registered provider was failing to notify us about occasions when people who used the service had sustained serious injuries or died. We informed the registered provider this was a breach of the Care Quality Commission (Registration) regulations 2009. Subsequently they started to send in notifications and we identified occasions when people had died unexpectedly or had been injured. We were concerned that the information indicated that the home may have neglected people's care and treatment needs and that the registered provider failed to understand the requirements of the regulations.

We found that the risks around ensuring people received safe care and treatment had not increased. People were at no greater risk than they were at the previous inspection from staff failing to administer medication in line with their prescriptions.

Hospital style beds were in place at the home which were fitted with bed rails; these were checked on a regular basis. As at the last inspection we did not see risk assessments in place for people with bedrails or consent from people with them in place. The home policy stated that best interest decisions needed to be in place for people using bedrails. However during our inspection, we observed people with bed rails in place without any best interest decisions available. We again saw that health and safety checks of bedrails were carried out by the maintenance team but not within the timescales set out by the registered provider. There was no guidance available for this which meant we could not be sure what checks were being carried out.

People were receiving adequate food and fluid. When people lost weight, we found staff were still failing to ensure referrals to dieticians were consistently made. We saw that for one person, the MUST nutritional screening tool had initially been completed 20 October 2015, which showed the person weighed 52.1kg. They were not weighted again until 13 March 2016 and then weighed 48.2kg (this means there was a five month gap in recording weight. This was a concern we had also raised in the April 2016 inspection and it was clear that the problems persisted.

We saw that staff had incorrectly scored MUST following the weight loss and this led to them not identifying people at risk of malnutrition. If staff had scored the tool correctly and followed guidance the person should have been weighed weekly. We asked to see the weekly weights and saw that people who had been noted as at risk and needing to be weighed weekly were not. For instance, one person was to be weighed weekly but they were only being weighed on a monthly basis. We asked the nurse about weekly weights and miscalculation of MUST but they did not appear to be aware that there was an issue. This was a concern we had also raised in the April 2016 inspection and it was clear that the problems persisted. However, we did see that staff were starting to refer people to the dietician.

At the last inspection we raised that people's dignity was compromised because staff undertook personal care with their bedroom door open. Also that staff did not consider people's dignity when they were sleeping and the custom and practice was to leave their doors open irrespective of whether they were in a compromising position or not fully dressed. We found the registered provider interpreted this feedback as

the need to close all of the bedrooms doors and disregard people's choices or needs.

The registered provider had completed fall risk assessments but had not used this information to inform the action they should take. Thus no fall monitoring systems such as pressure pads and motion alarms had been put in place for people who might be unsafe attempting to walk about in their room.

We discussed equipment that could be used to monitor the risk of falls but found the registered provider was unaware of this and failed to understand how this could be used to reduce the risks. However, we did note that the registered provider had started to refer people to the falls teams and seek external support to assist them to reduce the potential for people to fall.

We found that the registered provider had started to collate all of the information about injuries people had sustained but was yet to complete an analysis of this information.