Belle Rose Nursing Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 16 and 17 August 2016 and was unannounced. It was carried out by a single inspector.

Belle Rose Nursing Home provides accommodation, nursing care and support for up to 11 people with severe and enduring mental health conditions. Most people at the service had physical health needs alongside their mental health needs. The service is located in the centre of Dorchester and provides accommodation over two floors with a life to access the bedrooms on the first floor. People have access to communal living and dining areas and there is a garden to the rear of the property. Three of the rooms are en-suite and there are both bathing and wet room facilities available to people.

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 supported to receive their medicines by staff who had received appropriate training, however pain medicine for one person was given later than prescribed and although medicines were stored securely, temperatures were not recorded to ensure these were within safe storage limits.

Staff, relatives and professionals told us that the environment at the home could be improved and we saw that décor was dated and in need of improvement. We did not see that this had a direct impact on people, but the environment could have been improved and would have provided people with more pleasant surroundings

People did not have access to sufficient opportunities for social interaction or occupation. Staff on shift took people out on an as and when basis, this was dependent on the number of staff on each shift and how people were feeling. Relatives and staff also felt that people needed increased opportunities for social stimulation and to be able to go out more often.

At the previous inspection, we had made recommendations that the service consider opportunities for people to be involved in activities and interactions which reduced isolation and promoted health and mental wellbeing. We also recommended the service consider how all members of staff could be enabled to work as a team and have appropriate opportunities to share best practice. At this inspection, neither of these recommended improvements had been made.

People and staff felt that the registered manager was approachable. Staff told us that they were not listened to and they were not encouraged or empowered to help to develop the service.

There were no clear methods of gathering or using feedback from people, staff, relatives and stakeholders

and therefore none of these people had any regular input into the development or improvement of the service.

Quality assurance audits were completed regularly by the registered manager in a number of areas. However these audits were not providing a clear picture of trends or gaps in practice and did not reflect the evidence we saw.

People were protected from the risk of harm by staff who understood the possible signs of abuse and how to recognise these and report any concerns. Staff were also aware of how to whistleblow if they needed to and reported that they would be confident to do so.

People had individual risk assessments which identified risks to themselves and others and had clear actions to manage these risks. Some people had complex risks and staff were aware of what approach to use and their role in supporting people to manage risks.

There were enough staff available to support people and call bells were responded to quickly when people needed assistance. If people needed equipment, this was available and staff had received training and were confident in how to use this.

People were supported by staff who had the necessary training and skills to support them. Training was provided in a number of areas and refresher sessions were booked for certain topics on a regular basis.

Staff understood and supported people to make choices about their care. People's legal rights were protected because staff knew about and used appropriate legislation.
Several people at the service had complex mental health needs and also physical health problems. Staff were knowledgeable about what triggers and issues people faced and how to support them effectively. Staff were also able to communicate effectively and we saw that there was a good rapport with people.

People were supported to maintain a balanced diet and had choices about what they ate and drank. People enjoyed the food and had input into what menu options were and where they had their meals.

The service worked closely with outside agencies and records showed that people had involvement from their GP, tissue viability services, consultant psychiatrists and social workers.

People felt that staff were caring and told us that they had choices about their care. Staff understood their role in supporting people to make choices. We observed that staff were reassuring, calming and chatted with people.

People were supported by staff who knew their likes, dislikes and preferences. Staff told us that they communicated well and there were regular handovers at each shift change. There were no clear processes for the staff team to engage as a group and this meant that decisions tended to be made ad hoc by whomever was on shift rather that in an inclusive way.

People had individual care records which were person centred and gave details about people's history, what was important to them and identified support they required from staff.

Relatives told us that they felt welcomed at the service and people and relatives said that they would be confident to make a complaint or raise any concerns if they needed to.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to good governance of the service (Regulation 17). You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

Medicines were safely administered however improvements were needed in relation to timing of administration and temperature checks.

People were protected from the risks of abuse because staff knew how to recognise and report concerns..

Individual risk assessments were not always accurately completed

People were supported by sufficient numbers of staff who had been recruited safely.

Is the service effective?

Good

The service was effective.

Staff were knowledgeable about the people they were supporting and received relevant training for their role.

The service was working within the principles of MCA and people had comprehensive individual assessments which were decision specific.

People's mental and physical health needs were met by staff who were knowledgeable about what triggers and issues people faced and how to support them.

People at the service told us that the food was good and they had a choice about what they wanted to eat.

Is the service caring?

Good

The service was caring

Staff knew people well and were aware of their likes, dislikes and preferences.

People told us that they had choices about their care and staff

understood their role in supporting people to make choices.

People were supported to maintain their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

People did not have access to sufficient opportunities for social interaction or occupation..

People and relatives knew how to raise any concerns and told us that they would feel confident to do so.

People had individual care records which were person centred and gave details about people's history, what was important to them and identified support they required from staff.

Is the service well-led?

Requires Improvement

The service was not well led

Previous recommendations to improve the service had not been actioned by the registered manager.

People felt that the manager was approachable, however staff did not feel that they were listened to or that changes suggested were actioned.

The service did not have any clear systems for gathering feedback from people, relatives, staff or involved professionals.

Quality assurance measures were not providing a clear picture of trends or gaps in practice.

Belle Rose Nursing Home 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 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 16 and 17 August 2016 and was unannounced. The inspection was carried out by a single inspector.

We had not asked the provider to completed a Provider Information Return (PIR) . The PIR is a form that asks the provider to give some key information about the service, what the service does and improvements they plan to make. We gathered this information during the inspection. In addition we reviewed notifications which the service had sent us. A notification is the form providers use to tell us about important events that affect the care of people using the service. We also spoke with the local authority and Clinical Commissioning Group quality improvement teams to obtain their views about the service.

During the inspection we spoke with five people using the service, two relatives and two other professionals who had knowledge about the service. We also spoke with seven members of staff and the registered manager who was also the proprietor of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked around the service and observed care practices. We looked at the care records of four people and reviewed records relating to how the service was run. We also looked at three staff files including recruitment, training records and registration of trained nursing staff. Other records we looked at included Medicine Administration Records (MAR), emergency evacuation plans and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

The service was not consistently safe.There were regular stock checks and audits of medicines management were carried out monthly. The medicines audit tool had been recently changed to a more comprehensive audit tool. However, one person experienced pain on rising and was prescribed pain relief. This person was not supported to manage their pain as pain relief was administered after they were assisted to get out of bed rather than before. Checks on medicine practice had not identified this. We raised this with a registered nurse.

Medicines were stored securely. However, there was no system in place to ensure that medicines were stored at the correct temperature. The registered manager told us that they would introduce temperature monitoring checks.

Medicines were administered safely by staff who had received appropriate training. The registered manager told us that one person sometimes did not want to take their medicines when offered them by a trained nurse, however they would accept them from care staff. Care staff had training so that they could support this person to take their medicines. Another person was sometimes reluctant to take their medicines and could conceal them without taking them. Their care plan gave clear details for staff about how to encourage and support them by giving and explanation of why their medicine were important and observing tactfully until they had taken these safely.

People had individual risk assessments which identified risks to themselves and others and had clear actions to manage these risks. We saw that tools were used to assess and identify the levels of risks people faced with regard to their pressure care and malnutrition. Assessments which had been completed for people had not been completed or calculated correctly in several cases. This meant that the levels of risks were not always accurately recorded. For example, the pressure care assessment tool for one person had been calculated incorrectly which had identified that a person was at high risk, rather than very high risk of skin breakdown. Recent contract monitoring visits by the Local Authority and Clinical Commissioning Group had also identified gaps in the use of these recording tools. However, the service had not taken steps to ensure that the tools were being used correctly to ensure people's risks were identified. The registered manager told us that they would ensure that these were reviewed and completed correctly.

Risk assessments were individual and took into consideration how people's risks changed when their mental health deteriorated and how to support people during these periods. The registered manager had created graphs which showed patterns about how two peoples mental health fluctuated during a year. This meant that the service could be more proactive by identifying patterns of when people experienced a deterioration in their mental health.

One person had complex risks which they faced and staff were able to explain the approach they used to support the person and enable them to access the community in the safest way possible. Risks had been discussed with other involved agencies and a professional told us that the service was doing "as much as they can to manage these risks". For another person, they had risks around pressure areas which increased

when their mental health deteriorated and we saw that they had appropriate equipment and had sought specialist advice about how to effectively manage these increased risks. We saw that these were working well and that pressure areas had improved with the risk management plan that was in place. This demonstrated that people were supported by staff who understood how to reduce and manage their identified risks.

Staff understood the possible signs of abuse and how to recognise these and report any concerns. For example, one member of staff explained that because they knew people well, they would be able to pick up on any changes in behaviour or presentation which might indicate concerns. Staff were aware of the procedures to report concerns and the safeguarding policy had been recently reviewed and included contact details for outside agencies including local authorities in the nearby area. Staff were also aware of the homes policy on whistleblowing and this had been recently reviewed and included relevant contact numbers for external organisations including CQC. Staff told us that they would whistle-blow if they needed to People and relatives told us that they felt safe with the support they received at the home. A person told us that staff "do anything that I want them to". One relative told us that the home provided a safe environment for their loved one. A social care professional told us about a person with extremely complex needs and said that the service were "doing the best they can" to ensure that the person was as safe as they could be.

We observed staff supporting people safely and responding to call bells promptly. For example we saw a member of staff walking with a person, they were walking alongside them and reminding them to take bigger steps and to slow down. We observed another staff member supporting a person who was sat in the back garden at the service. It was a sunny day and the person had a hat on to protect their head, the member of staff supported them to apply sun cream to protect their skin.

Staff told us that they had the necessary equipment available to support the people living at the service. We saw that other equipment which might be appropriate had been suggested or trialled with people and staff were confident about what equipment people needed and how to use this. Additional equipment was in place which might be appropriate to support someone if they were to have a fall and would reduce the need for emergency services.

There were enough staff available to support people. We observed that people did not wait for support and that staff were able to support people when and how they wanted. One staff member told us that they needed three staff members on shift to be able to support people to access the community and this was not always possible due to staff vacancies. The registered manager told us that they had staff vacancies which they had successfully recruited to, but the new staff members had not yet commenced in post. They were using some agency staff to provide cover and the registered manager was also covering some shifts. Staff told us that there were enough staff if they had no vacancies and we saw that staff were flexible about changing and covering additional shifts. The service had a qualified nurse working 24 hours every day and care staff working day shifts and waking nights. There was also a chef, cleaner and a maintenance person. We saw the staff rotas for two weeks and saw that there were several gaps which the registered manager was trying to fill. They told us that they had contacted local recruitment in additional to the domiciliary care agency they used, to ensure adequate cover until the new members of staff were able to start and complete their inductions.

Recruitment records we looked at showed that appropriate pre-employment reference and identity checks had been completed prior to new staff starting. We also saw evidence that checks with the Disclosure and Barring Service (DBS) had been completed. Trained nursing staff had valid registration with the Nursing and Midwifery Council (NMC) and a trained nurse told us that they had recently revalidated, along with the

registered manager.

Fire evacuation procedures were easily accessible and copies were also in people's care records. Each person had a person emergency evacuation plan (PEEP) which included details of what support they would need to evacuate the premises safely. The fire safety book contained relevant emergency contact numbers for services and contractors in the local area. The maintenance person completed regular checks on the fire alarms, fire exits and extinguishers. There were also appropriate checks for gas safety and there was a quarterly fire alarm service test.

Good

Is the service effective?

Our findings

Staff, relatives and professionals told us that the environment at the home could be improved and we saw that décor was dated and in need of improvement. For example, the paint work in one person's room was chipped and cracking and carpets were very thin and worn. Some people did not have carpets in their bedrooms and there were some thresholds to access communal areas of the home which would mean accessibility could be difficult for people with reduced mobility or who required a wheelchair to mobilise. Relatives told us that the environment was dated and dull, but did not feel that this impacted on the care their loved ones received. Outside professionals also felt that the décor needed attention and one commented that "investment in the home is an issue". We did not see that the decoration of the home had a direct impact on people, however the environment could have been improved and would have provided people with a more pleasant living environment. The registered manager told us that they did not have funding available to make changes to the decoration of the service, however staff told us that they had offered to do some improvements in their own time. There was a maintenance book which staff used to record any issues and the maintenance person explained that they checked this during each shift and responded to issues promptly. There was no clear impact on people but this demonstrated that the service had not done all that was possible to create a pleasant and welcoming living environment for people.

People were supported by staff who had the necessary skills to support them. One relative told us that staff were managing their loved one well and had the right "skills and approach to support them". A professional explained that they felt staff had the necessary skills to be aware of a person's needs and how they presented when their mental health deteriorated. Staff were knowledgeable about the people they were supporting and received relevant training for their role. Supervision was bi-monthly and provided by the registered manager, deputy manager and one of the trained nursing staff. Records showed that staff discussed a range of topics including learning and development opportunities. Some staff told us that they had been unable to undertake particular training opportunities because of the needs of the service. Inductions for new staff were planned and staff were given a pack of information and undertook a four day programme which included shadowing and learning from other staff in areas such as personal care, preparation of meals and drinks and fire safety. The registered manager told us that staff appraisals were overdue and they were in the process of arranging these with staff.

Training was offered in a range of areas and some topics were mandatory for staff. These included manual handling, infection control, safeguarding and medicines competencies. Some training was face to face, but the majority was either through the use of workbooks or online learning. Workbooks were sent externally to be marked and staff had training certificates on their records. The registered manager said that they offered staff the option about what method they used for some of the training opportunities. A member of staff told us that learning and development opportunities were displayed on the notice board in the office for staff. We saw that two training courses were on display during the inspection and staff were encouraged to attend.

Staff told us that they communicated well and there were regular handovers at each shift change. Staff were positive about the use of these handovers, one said that they were "useful and tell us what we need to

know". Another member of staff told us that handovers provided an update about people and that they also checked their daily notes. They also said that any important issues were verbally discussed and explained. Another member of staff said that there were " a lot of close interactions and discussions here, if we needed everyone's opinion at once, we would call a meeting". We observed one member of staff updating a colleague about someone whose mobility had been poor that morning, they recommended that the member of staff provide closer supervision because of this. Another staff member said that discussions were on an ad hoc basis and therefore only included the staff on shift at the time. This meant that not all staff had input into discussions about practice or what was happening with people at the service. The registered manager told us that discussions about people and good practice happened in supervision and that every person was discussed at each shift change. This meant that staff did not always have the opportunity to work as a team and all have input into discussions about peoples support or to share good practice and ideas.

Staff told us that they worked well together and communication was good. We observed that the staff were comfortable and respectful of another, there was appropriate relaxed banter and members of staff worked together to ensure that support was provided for people in an effective and timely way. For example, a member of staff was assisting to support people during the early part of their shift and checked with colleagues before they then supported someone to go out into the community. Staff discussed what support people needed and worked in the kitchen at tea time to ensure meals were prepared and provided promptly. The trained nurse on duty guided and checked in with staff and they all worked together as an effective team. Most staff had been with the service for a number of years and had built up close working relationships.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA and found that people's records had comprehensive individual assessments. For example, for one person the service had worked with other involved professionals to complete an assessment of their capacity with regard to a specific decision. The assessment had deemed that they had capacity to make this decision, but it was a complex issue and the service had then worked with the person to support the risks which resulted from their decision. For another person, we saw that they had a MCA and best interests decision and the service had made an appropriate application to Deprivation of Liberty safeguards (DoLS) and that this had been granted. We also saw that a request had been made for extension of a persons DoLS where this was required. Some people at the service went out independently into the community and we saw that there was a sensor in place by the front door. This was used to inform staff about when people went out and when they returned to ensure that they were safe and free from harm. Some people had restrictions in place with regard to when they went out and there was a DoLS in place which related to this.

Staff communicated well with people and knew what methods of communication were most effective. For example, we saw that one person was sometimes resistive to support form staff. MCA had been completed but there had been no best interests decision. The registered manager told us that they had worked on methods of communicating with the person and that they used flash cards to assist the person to understand. This was working well and the person had been accepting support from staff, this meant that a best interests decision had not been required and demonstrated that the service had considered the least restrictive option for the person.

Several people at the service had complex mental health needs and also physical health problems. Staff were knowledgeable about what triggers and issues people faced and how to support them effectively. Although the service was not registered to accommodate people detained under the Mental Health Act 1982, staff were aware of the relevant after care provisions which affected many of the people living at the service. One person presented with different behaviours and increased risks when their mental health deteriorated and staff were able to explain these and how they changed their approach to be responsive to the person's needs. This included a change to how they managed pressure care and wound dressing, how they supported the person with eating and drinking appropriately and increased supervision when mobilising. This demonstrated that people were supported safely when their needs altered by staff who were effective in recognising and responding to these changes.

People at the service told us that the food was good and they had a choice about what they wanted to eat. One person said that the food was "very nice, you get your two choices. They come round with a sheet and ask what I want". Another person told us "the food is good and I like the choices". Records gave details about how people were supported to manage meals. For example, one person's record explained that they needed food to be cut up and also gave information about foods the person liked and disliked. For another person, there had been concerns that they were not eating enough. We saw that appropriate referrals had been made to their GP and their weight was regularly monitored. Staff were aware of what foods the person liked most and provided prescribed supplements in addition to a range of foods. We saw that the person had a food chart and staff were working to encourage them to eat at different times to suit the persons preferences. The chef explained that often the person didn't want their main meal at lunchtime and they instead provided this later on which suited them better. Some people at the service had small appetites and the chef showed us that they used smaller plates so that they weren't overwhelmed by the amount of food one person told us that they had a special plate which they used. Other people had particular cups which they liked to use and we saw that staff ensured that people had these provided at mealtimes. Care staff prepared the foods for tea time at the service and people had choices which included sandwiches or some hot options including jacket potatoes. The chef told us that people had been involved in the choices which were offered and they also had some regular meals including fish and chips and roast dinners. New options including Fajitas were also tried and if a person did not want either of the choices, the chef told us that they would prepare something else for them This demonstrated that people were supported to eat and drink enough whilst maintaining a balanced diet.

People had access to healthcare services. Belle Rose worked closely with outside agencies and records showed that people had involvement from their GP, tissue viability services, consultant psychiatrists and social workers. One person had been seen by their GP, dentist and district nurse and the service used an appointments book to ensure that staff were aware of any planned appointments or visits from outside agencies. A member of staff told us that they had regular contact with the GP for one person because they were concerned about a health condition and that the person could be experiencing pain. One of the trained nurses told us that they had a strong working relationship with the GP surgery and local pharmacy and had developed a rapport with these health professionals with whom they had regular contact. An outside social care professional told us that the service contacted health agencies promptly where needed and contacted them appropriately to seek professional guidance and advice.

Good

Is the service caring?

Our findings

People and relatives told us that the service was caring. One person explained that staff called them by their preferred name and that they "listen and are helpful". Another person told us that staff were helpful and "they know what I like and dislike". A relative said that "staff do an amazing job, stay cheerful and cope in a kind and caring way". People's records detailed how to support people in a caring way. For example, one record guided staff to gently encourage the person and to explain what was going to happen, providing a full explanation to reassure them. We observed staff supporting people in a caring manner. For example, a person called out to a staff member and asked for support to walk to the dining room. The staff member responded quickly and walked with them, reassuring and chatting as they made their way to the person's seat. This demonstrated that staff treated people with kindness and supported people in a caring way.

People were actively supported to make decisions about their care and staff understood their role in supporting people to make choices. One person told us that they chose "when I get up and go to bed, they ask what I want". Another person told us that they liked to get up early and staff supported them with this. We observed that a person told a member of staff that they were not ready for lunch and the member of staff supported them to the lounge instead as this was what the person wanted to do. Records encouraged staff to respect the choices made by people. For example, one advised staff to encourage and guide a person about what clothing would be appropriate for the weather, but to respect their choice and discuss their likes and dislikes with regard to colour and style of clothing so staff could offer appropriate choices.

Staff knew people well and were aware of their likes, dislikes and preferences. For example, a member of staff explained how one person was affected by their mental health and that they focussed on what they were able to try to do themselves and what they enjoyed to do. Another member of staff explained that a person coped better with some activities if they were told about them in advance and this reduced their anxiety. The service had a keyworker system in place and staff we spoke with had a very good knowledge about the people they were key worker for. The key worker provided the majority of support for a person and this enabled people to form strong bonds and trust with people. For some people whose mental health included anxiety and who needed reassurance, the keyworker system worked well and enabled them to build confidence in staff. A social care professional told us that staff "understood the person greatly, they seemed to have a good knowledge" about what they liked. Peoples records included details about their likes and preferences and included topics of conversation and interests people had. This demonstrated that people were cared for by staff who had a good understanding of their preferences and how they wished to be supported.

We observed a mealtime at Belle Rose and saw that there was a relaxed atmosphere with music playing in the kitchen and staff popping in and out of the dining room throughout the meal. Staff checked and engaged with people and we saw that meals were taken to peoples rooms promptly if this was where they preferred to have their meal. Staff knelt down with people who were sat at the tables when they were chatting and we saw that some people were engaging with each other which made the mealtime a more social event. Staff told us where people preferred to sit and why and these choices had been respected. One member of staff said they were "cheerful, if you can have jovialness it's a great healer". We saw that staff

were cheerful and friendly with people and that was a clear rapport. Two professionals we spoke with felt that staff showed genuine care for people, one told us that staff had a "nice warm way of trying to engage with people". Another said that staff "genuinely care and hold the people in high regard". We observed a member of staff stopping to compliment a person about their hair. The person thanked them and they then chatted together. Staff were aware of peoples communication needs and we observed that they changed their approach to speak with people differently in response to their individual needs. For example, one staff member explained that one person sometimes misinterpreted verbal communication and staff ensured that they spoke slowly and were reassuring which aided better communication. This demonstrated that staff were supporting people to express their views and encouraging them to make decisions about their care.

People were supported to maintain their privacy and dignity. We observed that staff were respectful and knocked on people's door before entering. They ensured that doors were closed when intimate care was being provided and encouraged people to maintain their privacy where possible. For example, one person exhibited disinhibited behaviour and there was a clear plan in place to support them to maintain their privacy by being vigilant about how their disinhibition may present and how to respond to this.

Requires Improvement

Is the service responsive?

Our findings

Staff told us that people did not have sufficient opportunities to go out. One said that it was "rare that they get to go out" and told us that some people had said they would like to go out more if they were able to. Another staff member said that they were usually able to get "one or two people out each day with staff available". They also told us that a volunteer visited weekly from a local organisation and was working with individual people to try to find local community links which may be of interest for them to attend. Another member of staff said that they did not feel that people had enough to do and that people were "content rather than stimulated, they would all benefit from going out more". Another member of staff told us that people had access to lots of puzzles and games at the service, but did not want to do these. We observed that there was a puzzle in the lounge but people were not actively involved in using it. Staff were motivated and eager to support people to have increased opportunities to go out and felt that it would benefit peoples physical and mental health if they were able to go out more often.

One person was experiencing a deterioration in their mental health, in response to this, staff were supporting them to go out more frequently and this meant that there were less staff available to support other people to go out or participate in any activities within the home. The service did not have any activities planned weekly but had two external activities which visited regularly. Staff told us that this was every few months.

People and relatives also felt that they wanted increased opportunities for social stimulation. One person told us "I would like to go out more" and then told us some activities they would be interested in doing. Another person said " I don't go out as often as I'd like, but staff can take me if they are not busy". One relative was not sure what opportunities their loved one had for social stimulation and another told us "one of my main concerns is what they have to occupy their time". They told us that they would like the service to provide more opportunities to keep their loved one engaged and take them out to town or for walks. People's records showed what activities people might enjoy. For example, one noted that a person enjoyed magazines, papers and classical music. Reviews indicated that a radio had been tried but removed and that daily papers were now offered. We did not see evidence of the daily paper in the person's room during the inspection.

The registered manager told us that one person was supported to go to their preferred church regularly and the person told us that they were "grateful that they let me go". The registered manager told us about a range of activities that they had investigated for people. These included accessing film shows put on by a local charity, investigating bridge clubs and painting opportunities. When we last inspected, the service had arranged for people to communicate with their family members remotely using computer based communications. However at this inspection, the registered manager told us that people had not wished to use this. The registered manager told us that they arranged outings with people but on a 1:1 basis and they tried to get people out at least once a week and provide opportunities for people to attend local events if they wish to go. They also told us that they were considering the possibility of incorporating some sessions with an external activities co-ordinator, but this was not yet arranged or agreed. Two people at the service went into the community independently and this worked well, however there was little in the way of

stimulation for people who remained in the home. We observed that people sat in the main lounge watching TV or sometimes in the garden at the rear of the property where people were also able to smoke safely. This demonstrated that the service had not been able to successfully provide sufficient opportunities for people to go out as frequently as they would like, or find other activities or types of social stimulation which suited peoples individual needs.

Relatives told us that they felt welcomed at the service when they visited and were able to drop in when they chose. Staff were friendly and able to update them about their loved one and how they were. They had been invited to stay for meals and were offered drinks and snacks by staff.

Relatives told us that the home kept them updated and communicated effectively regarding the care of their relative. One relative told us that staff always "know what's been going on with my relative and can tell me". They told us that they had been contacted by the service with any queries or changes about their loved one. Another relative said that the service "ring occasionally if they have any queries" . They explained that staff always gave them an update when they visited but they would appreciate a "few more calls to keep me in the loop". We observed that the registered manager was having an unplanned chat with a person and their relative discussing their support and updating about any changes.

People and relatives knew how to raise any concerns and told us that they would feel confident to do so. One relative explained that they would feel confident to speak to the registered manager about any issues and people told us that they would speak with ether the registered manager or a member of staff if they were unhappy with anything. One person said "I'd feel able to tell the registered manager if there was anything I wasn't happy about". The registered manager told us that there had not been any complaints over the last 12 months but we were able to see the documentation used which included an overview of the issue, a plan for investigating the concern and proposed response to the complainant.

People had individual care records which were person centred and gave details about people's history, what was important to them and identified support they required from staff. For example, one person had lived in a certain way prior to moving in to Belle Rose, this impacted on the day to day support they required and how staff could support them in a way they would accept. Their care record gave clear details about what actions staff were to take and how to offer support to the person. We observed that staff were supporting the person in line with the information in their care plan. A social care professional told us that staff had been able to provide the information required when they visited and that "records were person centred". Care plans were reviewed monthly and we saw evidence of changes that were made as a result of the reviews.

Requires Improvement

Is the service well-led?

Our findings

The service was not consistently well led. Our last inspection of 31 July 2015 found that improvements were needed in relation to the activities people were offered and the way staff were supported to work as a team. We recommended that the provider took action in relation to this. At this inspection we found that action had not been taken.

People continued to have limited opportunities in relation to activities. The registered manager said that people were offered opportunities for activities and explained the various reasons why the opportunities considered had not been successful for people. For example, the registered manager told us that one person wouldn't attend if they were unable to smoke at the activity.

At the last inspection we had also recommended that the service consider how all members of staff were enabled to work as a team, have appropriate opportunities to share best practice and ensure they felt comfortable to share concerns. At this inspection we found that improvements had not been made. Staff did not feel confident that they would be listened to, this was the case with regard to whistleblowing, suggesting developments or improvements to the service. Staff still did not have a system for discussing or sharing good practice as a staff group or for discussing issues or ideas in an inclusive way. This demonstrated that the service was not well led and the registered manager had not acted on previous recommendations made by CQC and had not promoted a positive or open culture for staff who worked at the home. This was a breach of regulation 17(1)(2)(e) &(f) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

The provided continued not to have a system which enabled staff to work effectively as a team. People and staff told us that the registered manager was approachable and easy to talk with. One person said that "the registered manager is very good, very kind". A member of staff said that they were "a lovely boss, does a good job and works hard". The registered manager worked shifts at the service as a registered nurse and we saw that they had a good rapport with other staff and worked closely as a team. However staff did not feel they were encouraged to develop the service or their suggestions were acted upon. For example, two staff members told us that they were able to make suggestions, however they were not listened. A staff member said that they were "not asked about how to develop the service or encouraged to make suggestions, if we do, they are not listened to". Another staff member said that they had made suggestions, however they said that these were dismissed. A further staff member said that they "can put your point of view across, but it's not heard". One staff member said that they did not feel appreciated in their role.

Staff told us that they had volunteered their own time to help to redecorate the service for people but this offer had been rejected. Professionals told us that the registered manager was "really helpful and has a good understanding of the clients needs" and that they "understand people with complex and enduring mental health needs". The registered manager told us that there was a staff suggestion box so that staff could make suggestions about the service. However we observed that this was in a corner in the registered managers office and a member of staff said that they used to have a suggestions box but this was not in place anymore. This demonstrated that the service did not have a positive culture and that staff were not

encouraged or empowered to help to develop the service.

The service did not have any clear systems for gathering feedback from people, relatives, staff or involved professionals. Relatives told us that they had been asked for verbal feedback when they visited their loved one, but had not been invited to review how the support for their loved one was progressing or invited to provide any more formal feedback about the service. The registered manager told us that they had previously tried to gather feedback from stakeholders using a questionnaire but this had a very low response rate. They said that they had also tried residents meetings but these were not successful and had last sent out questionnaires to people about 18 months previously. The registered manager said that they gathered feedback verbally from people on an ad hoc basis. They told us that they had received positive feedback from a local mental health team and that people were happy at the service. They said "you know if they are happy, they love it". People we spoke with had expressed that they were not happy with the activities or social opportunities available and the registered manager did not report that this had been fed back to them. This demonstrated that the service had not done all that was possible to gather the views of people, staff, relatives and stakeholders and therefore none of these people had any regular input into the development or improvement of the service.
This was a breach of regulation 17(1)(2)(e)(f) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Quality assurance systems at the service were carried out by the registered manager and covered a range of topics. There was an annual business plan which summarised the service over the previous year and set out plans for the following year, these included a marketing plan and employment plans which stated that staff meetings would be two monthly at the service. The registered manager did not tell us that they planned to reintroduce staff meetings and said that these had not worked when they had tried them previously. Other audits were completed monthly and included reviews of care plans and checks of nutrition, and weight monitoring tools. There were no notes in the audits that any issues had been identified with the recording in these areas. However this was not in line with the evidence we saw that some peoples risk assessments had been incorrectly completed. This demonstrated that the quality assurance measures were not providing a clear picture of trends or gaps in practice and did not reflect the evidence we saw.

This was a breach of regulation 17(1)(2)(a) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Service had not responded to recommendations at last CQC inspection in relation to the activities people were offered and the way staff were supported to work as a team. Improvements had not been made at this inspection.