Dav Homes Limited

Belle Vue Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

This was an unannounced inspection which we carried out on 9 April 2015.

We last inspected Belle Vue Nursing Home in December 2013. At that inspection we found the service was meeting all its legal requirements.

Belle Vue Nursing Home is a 49 bed care home that provides personal and nursing care to older people, and people with dementia and physical disabilities.

There was a registered manager in place. 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 protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed,

Summary of findings

thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support. We found there were enough staff on duty to keep people safe.

People said staff were kind and caring. Comments included, “I checked five care homes before I came here and the staff being so friendly was one of the reasons I chose this place.” “The staff are very caring and capable, nothing is too much trouble to them.”

People received their medicines in a safe and timely way. However we have made a recommendation about the management of some medicines.

The necessary checks were carried out to ensure the building was safe and fit for purpose.

Menus were varied and a choice was offered at each mealtime. Comments included, “This place has a good reputation for food.” “The food is very good in fact excellent.” Staff supported people who required help to eat and drink and special diets were catered for.

Staff were kept busy and in some areas of the home staff did not interact and talk with people as there was an emphasis on supervision and task centred care.

Belle Vue Nursing Home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had received training and had a good understanding of the Mental Capacity Act 2005 (MCA) and best interest decision making, when people were unable to make decisions themselves.

Staff were provided with training to give them some knowledge and insight into the specialist conditions of people in order to meet their care and support needs.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the treatment they needed.

A variety of activities and entertainment were available for people, but they didn’t always meet people’s needs or preferences. We have made a recommendation about people who live with severe dementia or cognitive impairment being provided with person-centred activities and stimulation.

People had the opportunity to give their views about the service. A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to.

People said the manager was supportive and approachable.

The provider undertook a range of audits to check on the quality of care provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People told us they felt safe living at the service and family members also confirmed that their relative was safe.

Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

Policies and procedures were in place to ensure people received their medicines in a safe and timely manner.

Staff were appropriately vetted. Regular checks were carried out to ensure the building was safe and fit for purpose.

Good

Is the service effective?
The service was effective.

People received effective care as staff had a good understanding and knowledge of their care and support needs.

Staff were supported to carry out their role and they received the training they needed.

People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment.

People told us that the food was good. People's nutritional needs were met and specialist diets were catered for.

Good

Is the service caring?
The service was caring.

People's rights to privacy and dignity were respected and staff were patient as they provided support.

There was a system for people to use if they wanted the support of an advocate. Advocates can represent the views of people who are not able to express their wishes.

Good

Is the service responsive?
The service was not always responsive.

Staff were knowledgeable about people's needs and wishes. People received support in the way they needed because staff had detailed guidance about how to deliver their care.

Staff in some areas of the home did not engage and interact with people except when they provided care and support.

Requires improvement

Summary of findings

There were activities and entertainment available for people however more meaningful activities and were not available for people who lived with severe dementia or cognitive impairment.

People had information to help them complain. Complaints and any action taken were recorded

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff told us the registered manager was supportive and could be approached at any time for advice.

People who lived at the home and their relatives told us the atmosphere was good.

The home had a quality assurance programme to check on the quality of care provided.

Belle Vue Nursing 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 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 9 April 2015 and was unannounced.

The inspection team consisted of an inspector, an expert by experience and a specialist nursing advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people. The specialist advisor helped us to gather evidence about the quality of nursing care provided.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

Due to their health conditions and complex needs not all of the people were able to share their views about the service they received.

During the inspection we spoke with 12 people who lived at Belle Vue Nursing Home, six relatives, the registered manager, the clinical lead nurse, eight support workers, the activities organiser and two members of catering staff. We observed care and support in communal areas and looked in the kitchen and two people's bedrooms after obtaining their permission. We reviewed a range of records about people's care and how the home was managed. We looked at care plans for six people, the recruitment, training and induction records for three staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the registered manager completed.

We reviewed other information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also contacted commissioners from the local authorities who contracted people's care. We spoke with the local safeguarding teams and other professionals who were able to comment about the care provided. We did not receive any information of concern from these agencies.

Good

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather their views. Other people said they felt safe and they could speak to staff. Comments included, "Yes, I feel safe here, the staff are so good." "It is a good home and the staff are very kind and patient." And, "They are treating me fine." Relatives commented, "This place is so good. I couldn't fault it." "My (name) is safe here, there are always staff around."

We found the provider had a system in place to log and investigate safeguarding concerns. We viewed the log and found five concerns had been logged appropriately. They had been investigated and resolved to ensure people were protected from further harm.

The staff on duty told us they had received training with regard to safeguarding vulnerable people. They had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the registered manager. One staff member said, "I've just done some safeguarding training." Staff were able to tell us how they would respond to any allegations or incidents of abuse and were aware of the lines of reporting within the organisation. A staff member commented, "We're here to protect and safeguard residents who are vulnerable." And, "We do body checks, we walk around and observe how staff interact with residents and listen to their tone of voice." Another staff member said, "If I had any concerns I'd report it." Staff were aware of the provider's whistle blowing procedure and knew how to report any worries they had. Comments included, "If I had concerns I would speak to the resident, document it, report it to the manager and call the General Practitioner." "We discuss the safeguarding/whistle blowing policies at supervision."

People received their medicines in a safe way. We observed a medicines round and saw the nurse checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. The nurse explained to people what medicine they were taking and why, "I've got your Paracetamol tablets for you, do you want to take them with juice or water? They then remained with each person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration. All medicines were appropriately stored and secured. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Written guidance was available with the MAR, for the use of "when required" medicines, and when these should be administered to people who needed them, such as for pain relief.

The nurse told us four people received covert medicines. Covert medicine refers to medicine which is hidden in food or drink. Documentation showed the GP had authorised the decisions for the use of covert medicines, where people did not have mental capacity. However, the decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had not taken place with the relevant people. A best interest meeting involves care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests. The registered manager told us this would be attended to.

We recommended the registered manager considers the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and to keep people safe. They included risks specific to the person such as for falls, moving and assisting, nutrition and pressure are care.

Regular analysis of incidents and accidents took place. The registered manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to falls.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs and it was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

Good

Is the service safe?

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a 'handyman' was employed. Routine safety checks and repairs were carried out by the handyman such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with promptly. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Staff had been recruited correctly as the necessary checks had been carried out before people began work in the home. We spoke with members of staff and looked at four personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people. Copies of interview questions and notes were also available.

The registered manager told us staffing levels were determined by the number of people using the service and their needs. At the time of our inspection there were two nurses and eight care workers on duty to care for 48 people who lived at the home. The home was divided into units over three floors. The registered manager told us eight people who occupied the top floor came to other units during the day so only two floors needed to be covered.

We observed although there were five care workers and a nurse on the middle floor to support 24 people, staff were particularly busy because of the needs of the people and the layout of the units. There were three lounges/dining rooms on the middle floor and two staff members worked between two units where some people were confined to bed and some required total assistance for their care. For example, at lunch time we noted it was difficult for one staff member to monitor the food intake of people on one unit as they attended to four people who ate in the dining room, three people who took their meals in the corridor and one person who was confined to bed.

We observed on the Chillingham unit there were 12 people in the lounge/dining room. There were three members of staff however one staff member provided 1:1 support for a person and another member of staff was also inducting a new member of staff who had started work that day so in effect there were only two members of staff available for other people in the unit.

We considered the deployment of staff to the middle floor needed to be reviewed to provide adequate supervision such as at mealtimes. We also observed people on the Chillingham unit, which accommodated people who lived with severe dementia. We saw staff did not have time to engage with people apart from when they carried out tasks. The registered manager said there were two vacancies for care staff and he had recently recruited two care workers to join the staff team. He told us one of the new staff had just started work that day and they were receiving induction from one of the staff on duty in order to learn about their role. Therefore this situation did not usually arise and three people would usually be available to provide care and support.

Good

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs. Comments from staff members included; "Loads of training." "There's lots of training the manager's on the ball." "If I want training I get it."

The staff training record showed staff were kept up-to-date with safe working practices. The registered manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that gave them some knowledge and insight into people's needs and this included a range of courses such as; dementia care, palliative care, distressed behaviour, dignity, nutrition and equality and diversity. They had also received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training.

Staff told us they were supported to carry out their caring role. A new member of staff told us they were completing a two day induction which included shadowing experienced staff members and completing the required training. Care workers said they had regular supervision every two months and nurses received supervision every two months from the registered manager. One nurse said, "At supervision we talk about attendance, ideas for improvement, team issues, training needs and health and safety." Staff said they could approach the management team at any time to discuss any issues. They also said they received a six monthly appraisal to review their work performance. One staff member said, "We discuss the job description, performance, what has been achieved and what you want to achieve." Staff members all said they worked as a team and there was good communication.

CQC monitors the operation of DoLS. DoLS are part of the MCA. These are safeguards put in place by the MCA to protect people from having their liberty restricted without lawful reason. We checked with the registered manager that DoLS were only used when it was considered to be in the person's best interests. They were aware of a supreme court judgement that extended the scope of these safeguards. We found as a result, that five applications were being considered and six people were currently subject to such restrictions.

Records showed assessments had been carried out, where necessary of people's capacity to make particular decisions. For example, a mental capacity assessment had been carried out, as required by the MCA, because a person had limited mental capacity to manage their finances, except for "basic and small decisions." A Best Interests meeting had taken place with the person, their family and the nurse to discuss how the person should be supported to help them still maintain some responsibility with smaller expenditures. For another person, a 'lasting power of attorney' had been awarded on their behalf for their finances by the Office of the Public Guardian.

Staff asked people for permission before delivering any support. They said they would respect the person's right to refuse care. One person commented; "Staff ask my permission before doing anything with me." Other people confirmed they were asked for permission before receiving any care.

People were positive about the food saying they received good sized portions and nice food. Comments included, "The soup is especially good." "The food isn't bad." "We get plenty to eat." And, "The meals are nice." We saw the midday meal was well presented and hot. People said they enjoyed the meal which was cottage pie or toad in the hole with vegetables, followed by chocolate sponge and custard or ice cream. Drinks were available during the day.

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised tool Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss. Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid balance' charts. Referrals were also made to relevant health care professionals, such as, GPs, dieticians and speech and language therapists for advice and guidance to help identify the cause.

Information was given to the catering staff to ensure they were aware of people's specific dietary needs. We saw this information corresponded with people's nutritional care plans that identified requirements such as the need for a modified diet.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. Staff received advice and guidance when needed from specialists such as;

Good

Is the service effective?

community nurse, dietician, speech and language teams, behavioural team and GP. Records were kept of visits and any changes and advice was reflected in people's care plans.

People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so staff were aware of the current state of health and well-being of people. The nurses told us a handover of verbal and written information took place between the nurses for each shift. We also observed a handover that took place between two carers. Information about people's fluid/hydration, moods, behaviour, appetite and activities they had been engaged in were shared.

The environment was designed to help people to maintain some independence. People were able to identify different areas of the home. There was appropriate signage and doors such as lavatories, bedrooms and bathrooms had signs for people to identify the room to help maintain their independence.

Good

Is the service caring?

Our findings

People who lived in the home and their visitors were very positive about the care provided by staff. Comments included, “The staff are very good.” “They look after us very well.” “The staff are canny.” “It’s lovely here.” Relatives commented, “I moved my (Name) from another home to this one as I knew this one was so much better.” “The staff are very nice, I’m very satisfied.” And, “The staff are kind, they reassure (name).” “Staff are very caring and capable.” And, “It’s a good home, nothing is a trouble for the staff.”

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people’s needs and preferences which showed they knew people well. People who used the service were pleased with the care they received. They thought staff seemed knowledgeable about their care needs and family circumstances and knew how to look after them.

During the inspection there was a relaxed and calm atmosphere in the home. Staff engaged with people in a calm and quiet way. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance with a gentle touch on the arm. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner.

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as two plates of food, two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. We did not observe however on the Chillingham unit that people were offered a choice of food at lunchtime.

Staff treated people with dignity and respect. We saw staff knocked on people’s doors before entering their rooms and staff ensured any personal care was discussed discretely with people and carried out in private.

Relatives told us they were kept informed by the staff about their family member’s health and the care they received. One relative said, “I’m always kept informed.”

A health care professional we spoke to after the inspection told us the staff made prompt referrals for assistance to ensure people’s health needs were met appropriately. Staff then carried out any advice and instructions that were provided to ensure people’s needs were met.

Records showed the relevant people were involved in decisions about a person’s end of life care choices. For example, a person had an end of life care plan in place that showed it had been discussed with the person, her family and the GP. The care plan was reviewed regularly and detailed the “do not attempt resuscitation” (DNAR) that was in place.

There was information displayed in the home and in the home’s brochure about advocacy services and how to contact them. Advocates can represent the views for people who are not able to express their wishes. The registered manager told us one person had the involvement of an independent advocate.

Requires improvement

Is the service responsive?

Our findings

Some people who lived at the home could tell us about their experiences. Comments included, "We could do with more activities upstairs."

People's needs were assessed before they moved into the home to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort. Care plans were developed that outlined how these needs were to be met. Up-to-date written information was available for staff to respond to people's changing needs as care plans were in place that reflected people's needs as they had been regularly evaluated.

Staff responded to people's changing needs and arranged care in line with people's current needs and choices. The service consulted with healthcare professionals about any changes in behaviour and medicines.

Detailed information was available to help staff provide care and support when a person was no longer able to tell staff themselves how they wanted to be cared for. People's care records contained information about their life history, likes and dislikes which gave staff some insight into people's previous interests and hobbies when people could no longer communicate this themselves. Information was also available with regard to their wishes for care when they were physically ill and reaching the end of their life, or arrangements for after their death. For example, to record their spiritual wishes or burial requirements.

Relatives we spoke with said they had been involved in review meetings to discuss their relative's care needs, they also said their relative's care was discussed on an on going basis. People's care records showed that regular reviews or meetings took place for people and their relatives to discuss people's care and to ensure their care and support needs were still being met.

People confirmed they had a choice about getting involved in activities and a weekly activities plan advertised what was available. These included, "knitting club, pamper sessions, massage, cinema club, luncheon club, arts and crafts, roll up sleeves (people were helped to remain active with light domestic work such as dusting, table setting) current affairs and reminiscence. The activities person told us regular entertainment took place in the home. We saw a Tai Chi (gentle exercise) session being held in the conservatory and eight people attended, a current affairs session also took place. People told us a church service was held in the home every month.

The atmosphere in parts of the home was lively and busy as people moved around to sit where they wanted and chatted to staff and visitors. On the middle floor some people chose to sit in a group in the corridor and listen to music, we observed staff chatted and danced with them.

In the Chillingham lounge, which accommodated some people who lived with more severe dementia or cognitive impairment, there were no activities available to stimulate people. We asked the activities person in the afternoon when they would carry out any activities and they came upstairs and did some individual hand massage with people. We observed staff on the unit only engaged and interacted with people when they were carrying out a task with a person. For example, when they offered a person a drink, or when they helped people to mobilise and then for some people, we noted the conversation was only to give instructions. We saw people sat sleeping in the lounge for most of the day whilst a television showed day time television with subtitles displayed on the screen. People did not have the opportunity to move from their seat as meals were served to them in their chair. We saw care was task centred rather than person centred. This meant support workers carried out tasks with people rather than attending to them at a time they may choose and spending time sitting interacting with them. One person was allocated a member of staff for supervision to keep them safe and this person received more engagement with staff.

We were shown a specialist, "Jacuzzi" bath which was to help people relax as they bathed, we were also told pamper sessions were available for people however care plans contained limited written information about strategies to meet people who lived with severe dementia sensory stimulation needs. These strategies could include music and sounds and the therapeutic use of touch, such as hand massage. We saw no pictorial aids or orientation aids were available to help people relax or remain involved and aware of their surroundings.

We recommend that the service explores the relevant guidance in supporting people with dementia in meaningful activities.

Requires improvement

Is the service responsive?

The complaints procedure was displayed in the entrance to the home. People said they knew how to complain. Comments included, "I know how to, but I haven't needed to." "It's lovely here." I would not want to complain about anything." A relative commented; "In our view this is a good home, we visit regularly, and we've never needed to complain." Another person said; "I've never needed to complain about anything." "We have never had any cause for concern. The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained. One complaint had been received and investigated appropriately.

Good

Is the service well-led?

Our findings

A manager was in place who applied to continue their registration with the Care Quality Commission in July 2013. The registered provider had been pro-active in submitting statutory notifications to the Care Quality Commission, such as safeguarding applications, applications for Deprivation of Liberty Safeguards and serious injuries.

Staff said they felt well-supported Comments included; "The manager is very good, very supportive." "The manager is approachable, he'll listen." "The manager is very approachable, very supportive, that's why I'm here." "I help the manager, I've certain responsibilities." "I come to work happy, we've got a very good team, we all work together." "I love working here, there is a good morale." "We want to make everyone happy and comfortable, the more smiles we get the happier we are."

The registered manager said he introduced changes to the home to help its smooth running and to help ensure it was well-led for the benefit of people who used the service. Relatives and people who used the service said the registered manager was approachable. A person commented, "The manager is does a great job."

People told us there was a calm, friendly atmosphere in the home and this was reflected in the interaction between people and staff.

Regular meetings were held with residents and relatives. The registered manager said relatives' meetings provided feedback from people who used the service and their relatives about the running of the home. We saw any comments suggestions that had been made by people were discussed at staff meetings so any relevant action was taken e.g. the laundry and misplaced items of clothes and activities.

Staff told us meetings took place every two months. They were held to keep staff updated with any changes within the home and to discuss any issues. Meeting minutes showed recent meetings had discussed policies and procedures such as safeguarding, staff performance, infection control, people's care and record keeping. Manager's meetings were also held with other managers in the organisation, to discuss any changes to be implemented to enhance the running of the homes and consistency within the organisation.

Records showed audits were carried out regularly and updated as required. Monthly audits included checks on, documentation, staff training, medicines management, accidents and incidents, finances, nutrition, skin integrity and falls and mobility. Daily and monthly audits were carried out for health and safety, medicines management, laundry and maintenance of the environment. An infection control audit was carried out three monthly. The registered manager told us monthly visits were carried out by the quality assurance manager to speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans and staff files. A three monthly audit was also carried out by a representative from head office. These were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. A financial audit was carried out by a representative from head office annually.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to staff and people who used the service. Surveys had been completed by people who used the service in September 2014. Findings from the survey were positive.