Four Seasons Health Care (England) Limited

Belle Vue Care Home

Inspection report

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Date of inspection visit:
20 March 2017
22 March 2017
24 March 2017
27 March 2017

Date of publication:
06 June 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 20, 22, 24 and 27 March 2017.

Belle Vue Care Home is a purpose built care home registered to provide care for up to 52 people. On the days of the inspection there were 33 people living there. The home is set over three floors, with people receiving general nursing care on the ground floor and a locked unit for people living with dementia and mental health diagnosis issues on the first floor. The lower ground floor contains service areas, such as the kitchen. People living on the ground floor had significant physical ill health and were mainly but not exclusively older people.

Following their last comprehensive inspection on 18 July 2016, the home was rated as Inadequate and placed in 'special measures' due to concerns we identified. These included concerns from the preceding inspection of June 2015 which had not been addressed.

In 2016 we identified concerns in relation to people's safety, staffing levels, management and governance of the home, and lack of caring and respect for people's dignity. Following that inspection, we issued three warning notices in relation to Regulation 12 (Safe care and treatment), Regulation 10 (Dignity and Respect) and 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We met with the provider when they shared the actions they were taking to address the issues identified.

We found some progress had been made by the home when we carried out a focused inspection in December 2016.

We carried out this comprehensive inspection in March 2017. We found not all improvements seen during the focused inspection had been sustained. The required improvements identified at the comprehensive inspection in July 2016 had not been completed. We identified concerns in relation to people's safety, safeguarding, person centred care, dignity and respect, staffing and good governance.

The home did not have a registered manager, although this person's name will show on this report as they have not deregistered. There was an interim manager in post at the time of our inspection who had begun the process of applying to the Care Quality Commission for registration. 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.

During this inspection we found that the systems in place to reduce risks associated with people's care and support were not always effective and this exposed people to the risk of harm. In addition to this people were not protected from risks associated with the environment. Some areas of the home needed additional cleaning or maintenance, and there was a significant odour problem, particularly on the first floor dementia unit.

People did not always receive appropriate care and support as staff were not deployed in a way that supported people to have their needs met in a timely way. People were exposed to risk of harm. We observed occasions where people had to wait unacceptable amounts of time for support.

People's right to privacy was not respected and they were not treated with dignity. Staff did not routinely supervise the whereabouts of people. This meant people walked into other people's rooms uninvited. Some staff were kind and caring in their approach, however other staff were focused on tasks and had limited interaction with people who used the service. Supervision and observations of staff had not identified, or had not addressed these issues in a way that ensured people had positive experiences.

Staff interactions were not always supportive to people. Staff did not support people to make decisions and choices about their care. For example, staff asked people for their meal choice at lunchtime but they did not clearly explain what was on offer and encourage people to make a choice for themselves.

People were disengaged and under stimulated. They were not provided with appropriate person centred stimulation and some people were at risk of social isolation. People spent long periods of time on their own either in the reception lounge area, in their rooms or looking out of the window. We did not see any activities taking place during our inspection.

People were not always protected from risks associated with their care. Risk assessments were not always in place or written in sufficient detail to support people to receive safe care and support, or to manage identified risks. People did not always have sufficient detail in their care plans to provide guidance and direction to staff about how to meet their needs or to care for them in a personalised manner.

People waited extended periods of time for their meals, and some people had been left with their meals but were not offered encouragement or support to eat. Some people's food and fluid intake charts were not being accurately completed which could lead to confusion about how much they were eating and drinking.

People were not always being protected from the risks associated with medicines. During the inspection we observed unsafe practice. Staff were not always recording when topical creams were applied. Other aspects of medicines management were safe. We saw medicines were stored securely and records were maintained.

There was a lack of effective governance which put people at risk of receiving poor care. Quality assurance and audits systems were ineffective. Whilst systems were in place to assess, monitor and improve the quality of service for people, these had not identified the shortfalls found during this inspection and had not been effective in ensuring the home was compliant with the regulations. In addition to this, timely action had not been taken in response to known issues.

People and their relatives told us the quality, variety and choice of food had improved in recent months. Since the last inspection the home had employed a new chef who was passionate about providing people with nutritional, high quality restaurant standard food. However, we did not find the way that meals were served helped ensure people had a positive experience. The dining rooms were noisy, and people were not always supported well by staff to eat their meals.

People were supported by staff who had a good understanding of how to keep them safe, identify signs of abuse and report these appropriately. We found staff were recruited safely. Suitable checks were made to ensure people recruited were of good character and had appropriate experience and qualifications.

Improvements had been made to staff training and supervision. The registered provider had an induction and training programme in place that included training specifically to meet the needs of people living at the home.

We found the home was taking appropriate actions to protect people's rights and work within the principles of the Mental Capacity Act 2005 (MCA). Staff were aware of people's right to refuse support and asked people for their consent before they assisted them.

The provider had a written complaints procedure. Information about how to complain was provided to people and their relatives when they moved into the home and was displayed on the wall of both units. Relatives told us they knew how to make complaints.

During our inspection, we acknowledged the manager and interim clinical lead were working hard to make improvements. The manager had identified several areas of concern which they were trying to address. The manager was working hard to maintain a stable staff team and staff felt well supported by the management.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

We are considering our actions in line with CQC's enforcement policy. We will publish a further report that details what action we have taken at a future date . 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.

The environment was not always safe for people.

Risk assessments were not always in place or in sufficient detail to help keep people and others safe from risks associated with their care.

Staff were not deployed in a way that ensured people had their needs met in a timely way.

Systems to ensure people were protected from abuse were not effective as staff did not always recognise or report potential abuse.

People were not always protected from the risks associated with medicines.

Staff had been assessed during recruitment as to their suitability to work with people.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported in a way that managed the risk of them not eating or drinking enough.

Menus had been reviewed and choices offered a balanced and healthy diet.

Staff had received training designed to enable them to meet the needs of people.

A programme of supervision for staff had commenced.

People's rights were being respected and staff had a good understanding of capacity and consent issues. Applications had been made for deprivation of Liberty safeguards where needed.

Records showed people had access to healthcare professionals,

such as GPs, opticians and chiropodists.

Is the service caring?

Inadequate

The service was not caring.

People's dignity was not always supported and staff did not always treat people with respect.

People were not always supported to help them maintain their independence.

People were not supported to be involved in their care planning.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not person centred and lacked detail in areas relating to how to effectively support people.

People were not supported to pursue hobbies and interests and most people were left unstimulated.

Complaints were recorded and action was taken to address concerns.

Is the service well-led?

Inadequate

The service was not well led.

Action plans identified to address concerns from the last inspection had not been effective in making the changes needed.

Although auditing systems were in place they were not being performed
robustly enough to identify the issues seen during the inspection.

Staff we spoke with told us the manager was approachable and they felt supported in their role.

People and their relatives were given the opportunity to give feedback on the service.

Belle Vue Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

We carried out this inspection over four days on 20, 22, 24 and 27 March 2017. The first day of the inspection was unannounced. The first day of the inspection was conducted by two adult social care inspectors and an expert by experience. They were joined by an inspector from the hospital directorate to complete their training. One adult social care inspector returned on the other days. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We looked at the information we held about the home before the inspection visit, including the inspection history, previous reports and the action plans sent to us by the provider. We looked at other information we held about the home including statutory notifications. Statutory notifications are changes or events that occur at the service which the provider has a legal duty to inform us about.

We contacted the local authority and the Quality and Improvement Team who provided information about the service. We used all of this information to plan how the inspection would be conducted.

During the inspection we looked around the home and observed the way staff interacted with people to help us understand the experience of people who could not talk with us due to living with dementia. We also spent time carrying out a Short Observational Framework for Inspections (SOFI observation). SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care.

During the inspection we met everyone living at the home and spoke with two people who were able to speak with us. We spoke with seven relatives, ten care support workers, three registered nurses, four agency care support workers, cleaner, administration staff member, maintenance man and chef. We also spoke with a visiting healthcare professional. In addition, we spoke with the interim manager and the interim clinical lead.

We also looked at a selection of documents associated with the management and running of the home. This included quality assurance information, recruitment information for four members of staff, staff training and supervision records, policies and procedures and records relating to health and safety, equipment and premises. We also completed a tour of the premises to check on general maintenance as well as the cleanliness and infection prevention and control practices. We discussed the home's action plans and progress being made with regard to providing safe care and treatment.

Inadequate

Is the service safe?

Our findings

At an inspection in July 2016 this key question was rated as 'Requires Improvement'. The inspection in December 2016 found improvements had been made, although the judgement of requires improvement was not changed.

During this inspection, we found not all those improvements had been sustained and the risk to people's health and welfare had increased.

People living at Belle Vue had needs related to long-term medical conditions such as frailty, dementia and disability. Some relatives raised concerns that all of the needs relating to these conditions were not being met because they thought there were not enough staff on duty.

At the inspection in July 2016 staffing was made up of a registered nurse, and between four and five care staff on each unit. At that time there were 48 people living at Belle Vue, and CQC judged there were not enough staff at all times to meet people's needs.

At the time of this inspection, there were 33 people living at the home. Two of these people were, at some times of the day, receiving one to one support funded by the local authority because of their complex mental health needs. The manager used a staffing analysis tool to identify the levels of staff on each shift based on the number and dependency level of people living at Belle Vue, and the current levels were appropriate to support 52 people.

In the mornings, there was a registered nurse and four care staff on duty on each unit. In the afternoon staffing was reduced to one registered nurse and three care staff in the dementia unit, and one registered nurse and four care staff in the nursing unit. 19 people were living on the nursing unit and 14 on the dementia unit. Care and nursing staff were supported by the interim manager, interim clinical lead, cleaner, chef, kitchen assistant, maintenance men and contractors. The home used agency staff to maintain the staffing levels.

During our inspection we saw some people had to wait for long periods of time for support. For example, one person with dementia required staff to support them with washing and dressing. They did not receive this help until 12pm. Staff told us they had not been able to wash another person and they would have to wait until after lunch because they were too busy. We heard another person calling out to staff for attention, a number of times. They told us they often had to wait for staff to help them.

Staff told us they wanted more time to spend with people to meaningfully engage with them, and meet their social needs. We observed interaction with people was only initiated when they needed support with a physical care task, for example, when they needed to visit the toilet or needed support with their meal. In between these times, we observed that people were alone, disengaged and under stimulated. For example, we observed one person had been placed in a reclining chair facing towards the window in the dining room. This person was sat alone. We observed this person for forty five minutes. During this time we saw staff

walking in and out of the room, they did not go over to the person or speak to them. The person was not offered a drink and no one checked to see they were comfortable.

In the nursing unit we saw there were not enough staff to ensure timely and appropriate help was available to support people to eat. People had to wait to be assisted with their meals because there were not enough staff to do this at the time the meal was delivered to them. Staff were busy supporting people in their bedrooms, whilst other people waiting for support in the dining room.

This was a continued breach of regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Systems were in place to protect people but these were not being operated effectively. Staff told us they knew what actions to take to safeguard people from abuse, and explained what action they would take to report abuse, they did not always recognise the actions of others as possible abuse. For example, people walked in and out of other people's bedrooms and staff did not challenge or manage this. One person was semi-naked when another person walked into their room. No action was taken by staff in relation to this. We heard staff speaking with people in a way that appeared to mock them. Other staff did not challenge this.

This is a breach of regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were being exposed to the risk of harm. For example, one person's radiator cover had been broken. The inside of the heater, with sharp metal edges, was exposed. Records in the person's care notes showed the damage had occurred two days prior to the inspection. The action taken to manage the risk was to place a chair in front of the radiator. Although this person received one to one care (because of their mental health needs) between 8am and 8pm, they were supported by the staff on duty at other times, who we noted were very busy. This person was active and mobile and at risk of injuring themselves.

Some rooms did not have door handles and the metal spindle on one was sticking out into the corridor. People with mental health needs were mobile and walked past this. This exposed people to the risk of injury.

Another room was being used by workmen to store their tools and equipment. This room was left open on two occasions during the inspection. We had to draw the manager's attention to this on both occasions. This exposed people to the risk of harm as the room was accessible by people with dementia who were walking around the home.

We found electrical cable had come away from cable trunking and live wires were exposed. This was in a bedroom and the door to this room was open. A number of people walked around this unit and entered bedrooms. This was immediately brought to the attention of the manager who ensured the maintenance team dealt with it.

A large wooden garden type bench was unsecured in the corridor of the dementia unit. We saw one person lifting, moving and dropping the bench. A relative told us the bench used to be fixed to the wall but a water leak meant the wall had to be repaired and it had not been reattached. They told us lifting and moving the bench was a regular activity carried out by this person. This could result in injury to the person moving the bench or to others. We looked at the person's care records and did not see risk assessments or management plans in relation to this behaviour.

People were not able to call for help because call bells were not provided in all bedrooms. In the nursing

unit six rooms did not have call bells. As most of the people living in this unit did not leave their rooms, this meant people and staff could not use the call system to summon help or attention when they needed to. Where people had call bells, we saw that five were left out of people's reach. When we checked on the second day of the inspection, the bells remained out of the person's reach.

We spoke with the manager about these issues. They did not have an explanation as to why people did not have call bells or did not have them in their reach. They said they would deal with this immediately. When we checked we found appropriate action had been taken.

At the last comprehensive inspection in July 2016, staff did not have clear guidance on how to manage risks associated with people's behaviours and risks associated with long term health conditions. At this inspection we saw some improvements. However, not all these risks were being sufficiently well managed.

At our last inspection we saw that behavioural management plans were being developed for people living with dementia who presented with behaviours that might put them or others at risk. However, we saw some people displayed distressed behaviours which put themselves and/or others at risk, and these were not being managed. For example, one person clutched at their hair and another person hit themselves a number of times. Staff did not take action in relation to these behaviours to keep people safe from harming themselves.

Records did not all contain risk assessments in relation to those people who were at risk because of long term health conditions such as diabetes, breathing conditions or seizures. We bought this to the attention of the manager who immediately put these in place.

We spoke with the nurses about these risks. They demonstrated a good knowledge in relation to the management of long term health conditions. However, this did not always relate to the specifics of each person's medical condition and how these should be managed. Nurses had not recorded these management strategies for care staff to follow, or to inform agency staff who were working at the home frequently and were sometimes in charge of a unit.

Some people were at risk of developing pressure ulcers. One person had a pressure ulcer on their heel. Risk assessments and pressure relieving equipment were in place for all people at risk. However, when we checked mattress settings we found two pressure mattresses were not set correctly for the person's weight. There was no guidance in care plans or risk assessments to instruct staff on what pressure the mattress should be set to. These types of mattresses must be set at the correct pressure in order to reduce the risk of skin damage. We brought these concerns to the attention of the manager who immediately responded by checking all mattresses and checking people's skin for damage.

Some people were not having their personal hygiene attended to. For example, the records for another person showed they had been supported with only one shower in 21 days and had not had any baths. A staff member said they felt people were not receiving sufficient support to bathe and shower. Some people looked unkempt and had dirty and/or had not had their teeth cleaned.

People were not always being protected from the risks associated with medicines. During the inspection we observed unsafe practice when an agency nurse was giving out medicines. We brought this to the attention of the interim clinical lead on duty who took action immediately to address the issues, and make people safe.

Staff were not always recording when topical creams were applied. Records we looked at showed gaps in

the administration records. This meant staff could not be sure people were receiving the treatment prescribed for them.

The provider failed to take sufficient action to ensure care and treatment was provided in a safe way, and that identified risks were being mitigated or managed.

This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Further observations of people receiving their medicines, found those medicines were administered safely. Staff supported people to take their medicines in a way that suited them. Records were maintained and stocks of medicines tallied with records. Medicines were stored securely and at the correct temperature.

Information was provided to staff about when to give people their 'as required' medicines. This included actions that staff should take before relying on medicines, for example in response to behaviour that challenged. Staff used a pain scale to assess whether people who were unable to communicate verbally, were in pain. Some people required their medicines be given to them covertly and appropriate actions had been taken to ensure this was being carried out in people's best interests. Clear instruction was in place to instruct staff on how to give the medicines to ensure their effectiveness.

Advanced prescribing was in place for some people nearing the end of their life. Medicines had been provided to the home in 'just in case bags' This helped ensure that where a person was at the end of their life, medicine was immediately available to deal with any symptoms such as pain or excessive saliva. Some people at the home had been assessed as needing thickened fluids to help prevent choking episodes when drinking fluids. Staff were able to describe how these were used and were able to identify which people needed to have them. We saw that the powders used to thicken the fluids were stored safely.

Checks were undertaken to ensure staff were suitable to work at the home. This included obtaining references from previous employers, checking staff's eligibility to work in the UK and undertaking criminal reference checks.

Staff had information available to help them in case of an emergency. Personal fire evacuation plans were in place for people that would help staff to understand the individual support people they would need in the case of fire. Staff received a handover about people's needs and any particular risks associated with their care.

Where an accident or incident had taken place these were being recorded appropriately. Monitoring systems were in place to ensure any themes or patterns in relation to accidents and incidents were identified. Staff were aware of the processes in place for recording when an accident or incident had taken place.

Requires Improvement

Is the service effective?

Our findings

During our inspection in July 2016 we required the provider to make improvements relating to the management of people's nutrition and hydration, to staff training and to staff support systems. Following the inspection, we received an action plan from the provider saying how they had or would address concerns. At this inspection we found that the provider had made improvements to some areas but further improvements were required.

We observed the lunchtime meals in both units of the home. The dining rooms were noisy and lacked organisation, and not everyone received the support to eat and drink they needed.

For example, staff stood over some people during lunch but did not offer encouragement to those people to eat, when this was needed. We saw one person was given their meal but they did not attempt to eat any of it. After ten minutes a nurse offered them one spoonful. When they did not get a response, the nurse removed the plate of food, and did not offer the person anything else. People in their bedrooms waited an extended period of time for their meals, and we noted some people had been left with their meals but were not offered encouragement to eat, where this was needed. Staff removed these meals once they had gone cold without trying to prompt the person to eat, meaning some people did not eat a meal.

We saw that staff had left drinks in people's rooms but these were out of reach. We saw a person in the lounge area with an empty cup in their hand who raised it to their lips but staff did not take the opportunity to offer to refill the cup. A staff member expressed frustration that jugs had been left in people's rooms without glasses being provided for them to drink out of.

The management of risk of malnutrition and dehydration was not being sufficiently well managed. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in July 2016 we found staff training and support systems were not always effective. Staff questioned the value of the training offered to them and felt that e-learning did not have a positive impact on their practice or learning. During this inspection we saw that improvements had been made to training and staff had received more face to face training that was specific to their role.

Training records showed staff had received training which included caring for people living with dementia, moving and handling, safeguarding, fire awareness, first aid, infection control and end of life care. Certificates were seen on staff files and annual refresher training was attended by the staff team.

Staff said training had improved as there were some training sessions rather than just e-learning. They were positive about the training in relation to swallowing difficulties and understanding the different types of dementia.

The action plan submitted by the provider following the inspection in July 2016 said that all levels of staff

employed at Belle Vue would receive supervision and this would commence from 1 October 2016, and would be on-going. Supervisions had started. 20 of the 41 people working at the home had received supervision. The manager explained that supervision sessions had previously been undertaken on an ad-hoc basis. They had developed a new system which was currently being implemented for all staff which would ensure they received regular meaningful supervision. We looked at supervision records and saw that supervisions provided staff with the opportunity to discuss their responsibilities, areas needing improvement and to develop their role. Where areas for improvement were identified these were discussed and reviewed at their next supervision meeting. Records showed support to learn and develop was provided and issues were reviewed at the next supervision, and progress recorded.

The quality and variety of food had improved and people received meals that met their needs. Information about special diets was available and had been shared with the chef. Staff were clear about the differing textures of food needed to ensure people were not put at risk of choking. Sufficient action had been taken to ensure people received sufficient to eat and drink; and improvements to the environment were on going.

Relatives told us the quality, variety and choice of food had improved in recent months. One family member said how much their relative enjoyed breakfast, having two-three bowls of porridge. Another relative said the food was good and there was a new chef. They said their relative ate well and maintained their weight. One person told us they enjoyed the food, commenting, "Oh yes...good food here. I eat all my food up". Another person when asked if they were enjoying their meal said "I loved it" and "that was very nice".

Since the last inspection the home had employed a new chef who spoke with enthusiasm about providing people with nutritious, high quality restaurant standard food. The chef told us they visited the units every day to speak with people and relatives about the food and find out people's likes and dislikes and what meals were being enjoyed. They also attended residents and relatives meetings.

Staff were aware of people's dietary needs, such as those who required a vegetarian option, soft or pureed meals. Food allergies and intolerances were recorded in people's care plans and the chef was aware of these requirements. Records we looked at showed people were weighed regularly, three people had maintained their weight, one had put on weight and another had been losing weight. Where weight loss or gain was a concern the person's weight was monitored weekly and a referral was made to a dietician which ensured staff had appropriate support to enable them to meet people`s nutritional needs.

At the inspection in July 2016 we found the premises did not help people with dementia to understand or navigate their environment and not all areas had been well maintained. At this inspection we saw that some improvements had been made, although further work was required.
Signs were now in place that provided some visual and written information for people. This included a picture of a toilet and the word to help people to recognise and use the toilet independently. They were large and colourful to provide assistance to people trying to navigate their way around the building. The ground floor reception lounge area had been painted, and there was a new floor and we were told they had new sofas and chairs on order. Visitors also commented on these improvements.

The appearance of the dementia unit on the first floor was improved. We saw there were pictures, photos and film/song quiz questions displayed on the walls for people to look at and help staff and relatives engage with people. Bright colourful objects were left on tables for people to pick up and use. One corridor had been decorated to a seaside theme with photos, pictures and memorabilia linked to holidays.

Some people living at Belle Vue had dementia and would not be able to make some decisions. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions at particular times 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.

The home was taking appropriate actions to protect people's rights. For example, staff were aware of people's right to refuse support. Staff asked people for their consent before they assisted them and checked with them that they had understood their request. Staff asked people where they would like to spend their time. Records indicated discussions had been held and best interests' decisions made regarding areas where people lacked capacity to consent, for example, with regard to taking medicines.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications had been made for authorisations to deprive people of their liberty at Belle Vue Care Home. At the time of the inspection, due to a backlog of applications being processed by the local authority, two applications had been approved and others were waiting approval. Where people's liberty was being restricted, we saw the least restrictive measures were being used and the conditions of the authorisation were being followed; for instance where people received on to one support, their activities were not restricted and they were free to go wherever they wished.

Staff told us they ensured staff were kept up to date about people's needs during staff handover at the start of each shift. We saw there was a written record of the handover meetings which staff were required to read, for example after an absence from work, to ensure they were aware of any changes in people's needs.

People told us they were comfortable. Staff checked with people if they were in pain and needed pain relief. They also asked other staff to monitor people's well-being and to check later if they were in pain. Records showed staff contacted health professionals for advice and to share information about changes to people's health. For example, staff noticed that one person's diet and fluid intake had reduced and they appeared to be withdrawn. Staff immediately contacted the person's GP who reviewed their medicines and prescribed antibiotics for a urine infection. We saw that people's long term health conditions had been reviewed. For instance, one person had recently seen their diabetes specialist. People told us they had been visited by health professionals, such as their GP, dentist and chiropodist. People's families told us they thought they would be told if their relative had any health issues.

Inadequate

Is the service caring?

Our findings

At the inspection in July 2016 we found staff did not always treat people with respect and promote their dignity. The provider's action plan stated all staff would receive dignity training and staff conduct would be monitored. However, during the course of this inspection, we observed variable practice amongst staff. Some staff did not treat people with the dignity and respect.

In the dementia unit people's privacy and dignity were not respected. Two communal toilets did not have locks and staff did not routinely supervise the whereabouts of people. We saw people walked into other people's rooms uninvited. For example, a man walked into a woman's room; she was in bed and her lower body was exposed. He did not interact with the woman, but a lack of staff supervision meant her personal space was invaded. Staff said this was a regular occurrence. We saw a woman also walk into the same room and walk round the person in bed. We requested staff to intervene. A man walked into another person's room while we were talking to them. Visitors said this often happened.

The majority of people living at the home were not able to share their views about their experience of care at Belle Vue. We therefore spent some time carrying out a SOFI observation. SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care.

We observed many people were withdrawn for long periods of time. Some people had their head in their hands or they stared into the middle distance not responding to what was going on around them. People clutched at their hair, one person hit herself a number of times. Some people looked tired and despondent. Staff did not comment on this and did not make eye contact as they walked past people.

Most interactions between staff and people were task orientated. Staff provided drinks to some people, but did not use this as an opportunity to engage with them. On a number of occasions, staff did not take time to make eye contact and engage with the person at their height level, For example, some staff stood over people rather than stooping down to speak with them. Staff asked people if they were all right as they walked past them. However, they did not wait for the response and ensure the exchange was meaningful for that person. Some staff gave people a cuddle or a kiss but this was brief as they walked past.

People did not always live in a pleasant smelling, clean environment. On the first day of the inspection, some areas of the home had a strong smell of urine which was particularly noticeable in the dementia unit. During the other days of the inspection we noticed that the odours had improved but were still noticeable. Areas throughout the building, and some equipment, were not clean. For example, we saw brown marks on a pressure cushion that looked like faeces, objects for engagement in the lounge were grubby and stained, chairs in people's rooms had food on, there were stained and washed out sheets on people's beds and people's side tables were dirty.
Some people looked dishevelled and several people had dirty nails and their teeth were not clean. One person's records recorded they had refused to have their teeth cleaned for 21 days. There was no information to show what action had been taken to address this.

Relatives told us hairdressing was not routinely available. One family member expressed frustration that when a hairdresser did eventually visit, they were not informed so could not be with them to help them stay calm. Instead, they were told by staff that their relative had been restless so their haircut was left incomplete.

Visitors for two people living at the home told us personal care had improved in the last few months. For example, they said less people were walking round with wet or soiled clothing because their incontinence was not being managed. However, we observed one person sitting in a chair in the reception lounge. They were moving around uncomfortably in the chair and kept loosening and looking down at their trousers. When a staff member passed by they noticed and said to the person "[name] oh dear you've been widdling yourself haven't you – let's get you to your room and get you sat up in your chair properly". This demonstrated staff did not understand how to promote people's dignity and respect their right to privacy.

One visitor felt their relative's appearance had improved but another visitor said they were concerned about the lack of baths being provided for people. We looked at the care records for their relative. They told us their relative did not like having a shower but we saw they had been given two recently. They said their relative loved a bath and really engaged with this activity but they had only had support with this twice in 21 days.

One person, during lunchtime, actively tried to engage with staff. They commented positively on the food and asked staff to sit and spend time with them. One staff member sat briefly with them and reassured them but other staff responded from a distance as they were discussing meal choices with staff. One staff member ignored the person and walked past despite the person speaking directly to them. Another staff member echoed the comments the person made, which at times sounded like they were mocking them.

The failure to treat people with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Dignity and respect).

Some staff at the home did show care and compassion to people and spoke about them with affection. We saw one member of staff hug and kiss a person and this gave the person comfort. One member of staff said, "I like working here" whilst another said, "I love working here. The residents are lovely." We saw some instances of positive and caring support being delivered to people. We heard a staff member reassuring a person as they washed their hair, the person was unhappy and called for help. The staff member spoke gently and explained what they were doing. We saw them emerge from the bathroom, and the person looked at ease with the staff member and went to their room to have their hair dried.

An agency nurse who arrived around lunchtime and was assisting with meals, positively addressed people in the dementia unit. They made a point of chatting to people in a lively manner and even sang to one or two who were sitting in the lounge area. We saw other instances of staff supporting people in a caring way. Some staff were patient with people and encouraged them to retain their independence when moving around the home. For example, we saw a member of staff spent time with a person encouraging them to walk to the toilet. We also saw staff spent time explaining to people what they were doing, for example when they were supporting them to move using equipment. We saw they ensured they were comfortably seated in their armchairs before leaving them.

We found people's relatives were mainly positive about the services they received. One relative said the staff were very friendly. They added, "We've been with this group for 7 years. The home here has, how shall I put it? "sharpened up". It's more caring". Another relative told us they were happy with the care their loved one received, "I'm happy with him here". Another relative, who visited their loved one every day, told us they

were given lunch by the home. They said it was great as they could eat with their loved one and it saved them cooking at home.

Relatives and friends were free to visit whenever they wanted and private areas for visiting were available if they wished. We saw relatives visiting throughout this inspection. Those visiting were encouraged to spend time with their loved ones and take part in any social activities and meetings that were arranged.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection in July 2016 we found a breach of Regulation 9 of the Health and Social Care Regulations (Regulated Activities) Regulations 2014. This was because people were not receiving personalised care and treatment that was appropriate, met their needs and reflected their preferences.

Many people living at Belle Vue needed support to have their psychological needs met and to be engaged socially. We saw a number of people spent time on their own either in the reception area, in their bedrooms or looking out of the window. Televisions were on or music was playing in the lounges. The majority of staff relied upon these to stimulate and interest people. However, our observations demonstrated people were not stimulated or interested. One person said they were fed up listening to a same musical which they said played continuously in the reception. They told us they preferred classical music. Another person had a television on in their room which they were not watching. We checked this person's records and found that there was no information about what interested them or how they liked to spend their time.

We saw many people appeared withdrawn and disengaged with the environment. People were in a repetitive cycle of looking at the television, looking around the room and then closing their eyes and putting their head in their hands. One person was repeatedly picking up a bench as a form of activity. Staff did not offer alternative activities. We saw one person repeated hurting themselves. Staff did not comment on this or do anything to stop this behaviour.

We saw two staff using their knowledge of people and their lives and interests to engage with those people, and they did this skilfully. They used tools such as memory prompt cards and magazines. Other staff told us about the knowledge they had in relation to people. However, they were not using this to help people to engage with them. We saw objects and pictures which could be used by staff to make meaningful contact with people. However, they were not using these as tools for this purpose.

Interactions with people were not planned in a way that would add value and quality to their lives. Care plans did not always include information about people's backgrounds, personal histories, hobbies or interests which would help staff to engage with them. Information staff did know about people was not always recorded or lacked detail. Therefore it could not be assured that all staff had access to this important information.

Since the last inspection an activities co-ordinator had been employed to work at the home Monday to Friday mornings from 9am to 14.45pm. They had devised an activity plan and we looked at the plan for March, which was displayed in people's bedrooms. The activity for the day of our inspection was recorded as "Ipad". Staff told us that the activities coordinator would use the Ipad to access well known songs to sing with people during one to one interaction. It was unclear who would lead this as the activities co-ordinator was on holiday. We did not see any activities taking place during our inspection and staff told us there would be no activities whilst the activities co-ordinator was on holiday.

Other activities for March included films, sensory sessions, reading and music. However, these were group

activities which would only be beneficial to those able to take part in groups.

One person's record showed they had been involved in only four activities over a period of 13 days. The activities recorded were not tailored to the interests of that person.

Relatives who visited five times a week said they rarely saw any activities take place, although the said there had been a singer recently. A staff member said if they could make one change at the home, it would be to improve the activities available to people. They told us "people are sitting all day."

Staff did not consistently demonstrate insight or compassion into the impact of people's conditions on their mental health. Although staff had been given specific dementia awareness training we observed some practice which showed staff did not understand the impact of dementia on people's ability to process information. We saw some staff gave information too quickly to people, did not communicate at the same height as people and did not ensure they had gained eye contact and had made a meaningful connection with the person. We observed staff trying to get a person to go with them to their room. They did not explain the reason for this or get down to their eye level to speak with them, and communicate the meaning of the interaction

Aspects to the delivery of care did not put people first or give people choices around their care. We did not see evidence in people's care plans that people and relatives (where appropriate) were involved in the planning of their care. There was a lack of information around their spiritual needs, their likes and dislikes or their background. Staff did not support people to make decisions and choices about their care. For example, staff asked people for their meal choice at lunchtime but they did not clearly explain what was on offer and encourage people to make a choice for themselves. Staff communicated with people verbally. They did not use pictures, visual cues or objects of reference to help people understand what was being said and to be able to make a choice based on information they could understand.

Whilst some care plans included detail in relation to how to support the person in a person centred way, this was not the case for all people. For example, one person's care plan showed they needed help with personal care but did not provide the level of detail needed to help staff support that person in a person centred way. Another person's moving and handling plan told staff they can be resistive to being moved using the hoist, but did not give staff any guidance of how to move the person causing the least distress possible for them. One person's psychological assessment, acknowledged they spend time alone in their room and were at risk of social isolation. Staff were instructed to encourage them to do what they enjoyed and engage them in activities but there is no information about what those activities were.

People were not receiving person centred care in accordance to their wishes or care plans. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a written complaints procedure, which detailed how complaints would be managed and explained how people could escalate their complaints if they were not satisfied with the provider's response. Information about how to complain was provided to people and their relatives when they moved into the home and was displayed on the wall of both units. We checked the complaints record and found that concerns raised had been appropriately investigated and responded to. Complaints and feedback were monitored and analysed for trends and patterns. We saw that concerns related to the quality and choice of food had been identified and improvements had been made to the menu choices and quality as a result.

Inadequate

Is the service well-led?

Our findings

At our inspection in July 2016 we found the provider was in breach of six Regulations of The Health and Social Care Act 2008. We served three warning notices in relation to Regulations 17 (good governance), Regulation 12 (safe care and treatment) and Regulation 10 (dignity and respect) telling the provider improvements must be made.

We inspected again in December 2016 to see if the provider was taking action to meet the warning notice issued in relation to Regulation 12 and found that improvements had been made but some areas of progress were still needed.

At this inspection we identified improvements were still required and there were five breaches of regulations. These breaches had also been identified at the inspections in July 2016 and/or in June 2015.

We met with the provider following the inspection in July 2016 when they shared the actions they had taken and were taking to address the issues identified. They recognised they needed to make a number of staff changes to improve the culture in the home, and had done this. They bought in care staff from some of their other homes to act as positive role models. A new manager was bought in to work at the home, and was supported by a clinical lead. They introduced an open door policy and encouraged staff to share their concerns about care, which they did. The home had worked with the local authority quality team and with the local mental health team.

Despite this, improvements to people's care, support and experience were still required.

Actions to improve the culture in the home had not all been successful. Monitoring of staff and their behaviours had not resulted in positive change to ensure people were treated with respect, or supported in a way that had impacted positively on their experience of care, or quality of life. The provision of support remained focussed on achieving physical care tasks and did not support or achieve person centred care.

Although the management team had introduced a range of quality and risk audits, these were not effective in addressing the quality and risk issues identified by CQC during this and previous inspections.

The environmental audit and health and safety checks had not identified the environmental risks. They had not identified that work being carried out to improve the environment was exposing people to the risk of harm. An audit had identified the need to make changes to the environment to make it more pleasant for people to live in. Whilst some changes had or were taking place, the home still smelt strongly of urine in places, particularly in the dementia unit, and some furnishings were dirty and stained.

The care documentation audit had not identified that some risks to people had not been risk assessed or that some risks did not have care plans for staff to follow. The audit had not identified that care plans were not always person centred and did not always have the level of detail staff required to carry out their roles safely and in a way that was person centred.

Staff supervisions had started and were based on good practice. However, not all staff had received supervision. The manager told us they discussed staff attitude and culture during staff meetings and staff had received 'people's experiences' training to support change and promote positive outcomes for people. We saw some staff interactions which had not been addressed through this system, and which were not challenged by other staff.

In addition, the management team carried out competency checks and observations of practice. However, these actions had not identified that staff were not all treating people with respect or promoting their dignity. Some staff told us they felt there needed to be more oversight to ensure that people's care needs were met. They commented that some shifts had no senior cover, although a team leader had been newly appointed. Staff said they often felt nobody took responsibility to check on the work of care staff.
We received mixed views from relatives about the management of the home. One relative commented, "We have had a lot of managers recently, but since this new manager came the staff are a lot happier." Others said they could not get a sense of who was in charge.

The home had invited a person with dementia and who campaigns to raise awareness of the experience of dementia to come and talk to staff. However, this person did not stay to give their talk as staff had not been made available to meet with them and listen to their experiences.

Observations of practice and environmental audits had not identified that call bells were not available or not within reach for some people.

We saw a reminder in staff minutes that all agency staff must receive an induction and have their competencies checked prior to starting work when new to the home. This had not happened on the day of the inspection. The inspector had to intervene because of unsafe practice.

Care records were not all stored securely. The care records were in an unlocked cupboard in the nurses' office. On two occasions during the inspection the door was left open. This meant that any visitors had easy access to confidential information.

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

The registered manager at the time of the inspection in July 2016 left the service after the inspection. Since then, although there is no registered manager in place, an interim manager had been appointed. They had been in post since November 2016. They were supported by an interim clinical lead. They had identified some issues, particularly in relation to the environment and the culture in the home, and had worked hard to develop a stable team. Staff told us the manager had made a difference in the time they had been at the home. One commented the new management had brought 'professionalism' to the home.

The manager and interim clinical lead had taken steps to provide staff with the opportunity to share their concerns by adopting an open door policy, and worked with senior staff to address these. The manager had a listening, proactive style of management which was more likely to encourage open relationships and empower staff to be creative. We saw the manager and interim clinical lead were visible in the home and worked alongside the staff.

Some staff told us they felt well supported and confident in the way the manager ran the home. Staff said they could approach the manager with any concerns and felt they would deal with concerns appropriately. Staff praised the teamwork amongst care staff and other staff members saying there was "a good team" and

"we really work as a team." One person said "I love this home."

Staff had access to senior management by phone for advice and telephone numbers had been given to staff to enable them to contact management at any time. The management team told us they had ensured there was a presence in the home over weekends to help staff feel supported, monitor the service and help keep people safe.

We saw staff benefitted from regular team meetings. We viewed minutes from the last team meeting in February 2017. Topics discussed included staff attitude, completion of records, moving and handling and complaints.

People had the opportunity to attend residents meetings, which we were told took place regularly. A relative said there had been a recent meeting with the management team although it was poorly attended. The meetings discussed various subjects that included the quality of food, care and the service. Most comments about the home were positive. In addition, the home obtained feedback from people and relatives to identify areas that needed improvement and to assess the impact of the service on the people using it. Feedback was sent directly to the home's management and escalated within the organisation if concerns were identified.

The manager knew how and when to notify the Care Quality Commission (CQC) of any significant events which occurred, in line with their legal obligations. They also kept relevant agencies informed of incidents and significant events as they occurred. This demonstrated openness and honesty. The manager understood and was knowledgeable about the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.