Anglia Care Homes Limited

Bellevue Residential Care home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Bellevue Residential Care Home is registered to provide care and support for up to ten older people. The service supports people living with a diagnosis of dementia and or mental health needs.

We carried out an unannounced comprehensive inspection of this service on 02 March 2017. We identified a number of breaches of the legal requirements and the service was rated as requires improvement. We found that people were not sufficiently protected against risks, the premises were not clean and there were not always sufficient staff available to support people and meet their needs. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the concerns and we subsequently met with them to discuss the actions that they were taking.

We undertook this focused inspection on 28 November 2017 to check that the provider had followed their action plan and to confirm that they now met legal requirements. The inspection was unannounced and there were ten people living at the service on the day of our inspection. This report only covers our findings in relation to Safe and Well led. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bellevue Residential Home on our website at www.cqc.org.uk"

The service had a registered manager who was also a director of the company which owned the service. The registered manager was also registered to manage another care home for older people in Clacton which they also owned. 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.

At this inspection we found that sufficient action had not been taken and the provider remained in breach of the regulations. We found that some parts of the service presented risks to people and there was a lack of robust assessments and controls in place to protect people and keep them safe. The environment was not always well maintained and we continued to find issues with cleanliness. Some improvements had been made to the numbers of staff however we continued to have concerns about the numbers of staff at night and staff knowledge and skills. We identified that staff did not always display adequate knowledge about how to support people safely. We identified shortfalls in the management of risks such as aspiration, moving and handling, infection control and food hygiene.

Medicines were not managed in a safe way. Staff did not always following the supply pharmacist instructions and the amount of medicines administered did not tally with the records of administration. This meant people did not receive their medicines as prescribed. We also identified shortfalls with auditing and storage of medicines.

People's nutritional and hydration needs were not well managed and there was a lack of nutritious, fresh food available at all times. There was poor organisation and oversight of menus and over dependence on

frozen food. People were not protected from the risks of choking and did not always receive specialist diets as required.

Staff practice was not consistently caring and did not always promote peoples dignity. Care was not always delivered in a way that reflected best practice and personalised care.

There were quality assurance systems in place but these were not robust or effective. They were not driving improvement and had not identified the issues that we found at the inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review 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. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe.

Risks to people's welfare were not managed effectively.

There was not always sufficient skilled and knowledgeable staff deployed to meet the needs of people living in the service

People did not receive their medicines as prescribed. Medicine administration was not safe and did not always follow professional guidance.

People were not protected from the risk of infection,

Improvements were not being made promptly.

Is the service well-led?

Inadequate

This service was not well-led.

Leadership at the service had not been effective in driving improvement

The service was not developing in line with good practice

Audits did not address the shortfalls we found or promote individualised care.

Bellevue Residential 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by information received about concerns at another service for which the registered manager is also registered as manager. These concerns related to how concerns were managed and the overall governance. This inspection was unannounced and focused on the areas of Safe and Well led.

The inspection was undertaken by two inspectors. Prior to our inspection we reviewed information we held about the service. This included any statutory notification that had been sent to us. A notification is information about important events which the service is required to send us by law. The provider had completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also spoke with the quality team at Essex County Council about their visits to the service.

We spoke with two visitors and five members of staff and the registered manager. We observed how people were supported throughout the day of the inspection. We reviewed care and support plans, medication administration records, two staff records, staffing rotas and records relating to the quality and safety monitoring of the service. The providers management consultant also attended the feedback meeting at the end of the inspection.

Inadequate

Is the service safe?

Our findings

At the last inspection we identified that improvements were needed to ensure that people were kept safe. These shortfalls were a breach of the regulations and following the inspection the provider wrote to us and told us that they had addressed the issues we had identified.

At this inspection we found people continued not to be safe. We found continued issues with the management of medicines and the management of risks. We found that the management of the service and staff did not always take action to mitigate people from the risk of harm and therefore lessons had not been learnt and issues fully addressed.

Risks to individual's safety were not well managed. There were risk assessments in place but these were not always correct or adequately addressed the risks. Staff did not always follow the management plan. For example, we found that the service used the MUST tool which is a five step screening tool to identify adults who may be at risk of malnourishment. We found that this had been incorrectly completed for one of the people whose care we looked at and did not identify that they were losing weight. One person who had been identified as being at risk losing weight had not been weighed for six weeks.

One person who had been assessed as at risk of choking and should have been provided with a soft diet but we observed that they were provided with a normal diet. We observed that this person was coughing as they were eating their meal. We observed staff supporting another person who was a risk of aspiration and choking. The member of staff demonstrated a lack of knowledge about how to support people safely and we observed them pushing a large dessert spoon of food into their mouth with significant force until we asked them to stop.

A number of people using the service had been identified as at risk of dehydration and urinary tract infections. They were reliant on staff to support and monitor their fluid intake. However, records staff maintained indicated people did not receive adequate hydration to sustain health. People's records of daily fluid intake were not totalled and therefore were not monitored effectively. We also had concerns about the accuracy of the records as they did not correspond with our observations. We noted that a visiting professional had expressed concerns about one individual's fluid intake following their diagnosis of a urine infection.

Staff did not demonstrate that they had the knowledge to move people safety and we observed two members of staff using an underarm lift to assist an individual to reposition in their chair. This is not a recommended lift as it places people at risk of shoulder injuries. We asked the registered manager to urgently review how they manage risk and keep people safe.

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

We found some parts of the environment presented risks to people and there was a lack of environmental

risk assessments in place to guide staff on the steps they needed to take to protect people and reduce the likelihood of harm. We found a number of rooms on the first floor of the service had window restrictors in place which did not comply with nationally recognised health and safety requirements. The registered provider had started work to replace the window restrictors with an alternative fitting but we found the keys were accessible to people as they were attached in some rooms to the side of the windows. Window restrictors help to prevent vulnerable people falling from height.

The arrangements in place for the prevention and detection of legionella were not satisfactory. There was no effective risk assessment in place and we did not find evidence that checks of cold water supply, in pipe temperatures and checks on tank conditions were taking place. This leaves people living and working at the service at risk of contracting legionnaire's disease through the lack of appropriate management. We asked the manager to urgently review the systems in place.

There was a main staircase accessed via the communal entrance which had a stairgate in place to prevent people from accessing the stairs. However there was no stairgate or other system at the top of the stairs to prevent peoples falling down the stairs and this risk had not been fully considered. There were a number of sloping floors and no adequate risk assessment had been undertaken to ensure that they were safe for people. There was some evidence of portable appliance testing (PAT) testing being undertaken but this was not up to date. PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use, We found a number of items which the staff were unable to evidence had been included in the testing.

At our previous inspection in March 2016 we identified that the upstairs bathroom was cold and the radiator was not working. The provider told us they had taken action to address this. At this inspection we found that the bathroom was cold and the radiator remained cold throughout the day. This meant that people were not provided with adequate heating when bathing.

Other areas of the service were in need of refurbishment and re-decoration. There was a lack of routine maintenance. For example the windows at the rear of the service were in need of painting as bare wood was exposed. Walls in people's rooms were found to be scuffed and had damage to wall plaster. The laundry window was dirty and parcel tape was being used to hold the air vent in place. We noted that the laundry contained a number of chemicals hazardous to health where people had access as the door was not being consistently locked by staff.

We asked the registered manager to ensure that a number of safety concerns we identified to be addressed as a matter of urgency.

This is a Breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines continued not to be managed safely. We observed medicines left unattended in people's rooms on two occasions during the inspection. We saw that one person who was at risk of choking was given their medicines without them being crushed which was contrary to the prescribers instructions and placed this individual at risk of harm. We checked a sample of medicines against the administration records and found that they did not tally, indicating that some people may not have received their medicines as prescribed. One person had been prescribed Alendronic acid which should be given as per the prescribers instructions 30 to 60 minutes before food however this was not common practice and the staff we spoke with were not aware of the specific risks around the timings. People's pain was not always well managed and the pain management tool which was in place had not been personalised to each individual. We observed that the

controlled drugs cupboard was not sufficiently secure and had been replaced by a wall safe which was found hanging from the wall and could have been easily removed from the service.

We asked the registered manager to ensure that the medicine management concerns we identified to be addressed as a matter of urgency.

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

At our last inspection we identified a breach of the regulations, as there was not always sufficient staff available to meet people's needs. The registered manager told us that they had increased staffing levels at key points in the day to meet people's needs. At this inspection we found there continued, to be insufficient numbers of suitably qualified staff available to meet people's needs at all times

The registered manager used a dependency tool to support them in setting the staffing levels and we saw copies on peoples care records. However, we queried the accuracy of this tool as we were told that one person was able to reposition independently but this did not correspond with our observations. They were in bed permanently and at risk of acquiring a pressure ulcer. There was no system in place to guide staff in the need to reposition them and at night, insufficient staff available to enable them to do so safely.

Staff did not have sufficient level of training or expertise to meet the needs of the people living in the service safely. We could not see that they had undertaken training in supporting people who were at risk of choking and aspiration. Staff pureed a meat pie for the lunchtime meal but there was no assessment undertaken as to whether this was suitable for liquidising and there was a lack of clarity about the level of consistency required. One newly appointed member of staff did not yet have moving and handling training at the service but we observed them assisting people to move. We observed another member of staff who was providing some activities to people in the communal areas but they lacked understanding of dementia care and continued to wave a tambourine at one person despite them showing signs of distress at this activity. Staff performance was not monitored adequately as it has not identified the issues that we found at this inspection.

The shortfalls in staff are a Breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The system in place to protect people from infection and promote good hygiene practice was not safe and effective. Staff were not clear about their responsibilities and the service did not follow national guidance, which placed people at risk of harm. For example, we saw that one of the staff members who was preparing food was also providing personal care and we observed that they did not use any protective apron when moving between delivery of personal care and food preparation. Another member of staff returned some chicken nuggets to the freezer after they had been sitting on the side for a number of hours and were partially defrosted. They were not aware of the increased risk of food poisoning and we asked them to dispose of these food items.

On our tour of the service we found items which were in need of deep cleaning and replacement such as a toilet seat surround with rusted legs and peeling paint which was corroded and therefore presented risks of harbouring bacteria. Toilet light cords were dirty and in need of replacement. The staff toilets did not provide any hand wash or hand towels to enable staff to wash and dry their hands and reduce the likelihood of cross infection.

The shortfalls in infection control are a Breach of Regulation 12 (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in March 2017 we found the service was not well led and required improvement. At this inspection we found that there continued to be a lack of effective oversight and sufficient controls were not in place to mitigate the risks to people's health, welfare and safety.

The provider was also the registered manager. They also managed another nearby residential care home for older people, which they also owned. They were supported by a deputy manager. Following the last inspection we met with the registered manager to discuss how they intended to make improvements at the service. They told us that they had made changes at the service which included strengthening the management arrangements and auditing.

At this inspection we found that the registered manager did not have a clear understanding of the risks and issues facing the service. The systems in place for identifying, capturing and managing organisational risks were ineffective. They had not identified the risks to people's health, welfare and safety which we identified. They also failed to mitigate the risks of harm to people in relation to the environment.

The management and staff did not have a clear understanding of quality and the quality assurance system was not robust. We found that the registered manager maintained various checklists but these were largely ticked or stated all "ok". For example, in relation to infection control they had not identified that equipment needed replacement. In relation to care planning, they had not identified an individual's needs had changed and they could no longer walk independently. It was recorded that there had been no falls when we identified that one individual had recently fallen.

We were told that health and safety and medicine audits were being undertaken however despite repeated requests they could not be found on the day of our visit. The audits undertaken did not take account peoples experience and we observed that people spent long periods disengaged. Some individuals spent the day in bed and we were unable to find the rationale for this. We observed that they had nothing meaningful to look at and had little staff interaction outside of meal times. There was poor attention to detail for example, the curtains in some peoples room barely closed, and one individual did not have a headboard which meant their head rested directly onto electric sockets.

There was a lack of organisation in areas such as staffing and provision of food which impacted on the staff and the experience of people using the service. There were menus in place but the food items were not available We found that the food cupboards were poorly stocked with food and some items were out of date. Some of the foodstuffs were not of a high quality, nutritious or appetising. For example soup had been prepared for the evening meal in a saucepan which had been used to prepare the lunch. It had not been washed and there was residue around the saucepan and lid. Staff were unable to tell us what type of soup had been prepared for people to eat at the teatime meal. The soup looked so unappetising it was thrown away. Individuals identified as being at risk of malnourishment and choking were served powdered soup sprinkled onto pieces of bread with hot water.

We found that staff needed further direction and leadership. They did not always work in a person centred way or display values such as compassion and care. We observed some poor interactions such as a member of staff pushing a table towards an individual to prevent them from getting up out of their lounge chair. This action prevented them from walking around the building as they intended to do so. We saw that no attempt was made to engage or speak to the person throughout the day other than when they were told to 'sit down'.

We observed a member of staff leaving an individual who they were supporting to eat with their mouth covered in food residue. They did not treat the individual in a dignified way and when they returned they cleaned their mouth with the clothes protector and a hard paper towel without telling them what they were doing.

The registered manager told us that training was provided for staff and checks were undertaken on staff understanding and competency. We looked at a sample of these checks and saw that staff practice had been observed and signed off as competent. The checks undertaken were not sufficiently robust and did not provide adequate performance management.

The lack of effective governance and oversight is a Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to mitigate the risks to people using the service Medicines were not being managed in a proper and safe way Further work needs to be undertaken to prevent and control the spread of infections

The enforcement action we took:

We issued an Urgent Notice of Decision restricting admissions to the service. We required the registered person to ensure that all service users needs were assessed to identify those which require a specialised diet and their care plans updated to enable staff to have the relevant information to ensure nutritional, hydration and medication needs are met safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment must be suitable, suitably used and properly maintained

The enforcement action we took:

We issued an Urgent Notice of Decision requiring the provider to commission a Health and Safety assessment and action this to address risks at the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems to monitor and improve the quality and safety of service were not working effectively

The enforcement action we took:

We issued an Urgent Notice of Decision on the Registered Person requiring them to commission an independent review of training needs at the service which must include as assessment of competency, staff understanding and learning gaps. They were also required to ensure that there is sufficient food available

to meet service user's nutritional needs so that service users receive a healthy intake of fresh food

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably competent and skilled staff were not always available to support people

The enforcement action we took:

We issued an Urgent Notice of Decision on the Registered Person requiring them to ensure that there is at least one member of staff on shift at all who has relevant experience of food preparation, an understanding of food hygiene requirements and a knowledge of serving food to people who require specialist diets. They were also required to ensure that a member of staff was present at all times with the skills to administer medication safely.