Eastgate Care Ltd

Belle Vue Lodge

Inspection report

680 Woodborough Road
Nottingham
Nottinghamshire
NG3 5FS

Date of inspection visit:
02 May 2018
03 May 2018

Date of publication:
22 June 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 2 and 3 May 2018. The inspection was unannounced.

Belle Vue Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Belle Vue Lodge is a nursing home and accommodates up to 59 people in one building. There are six individual units over three floors. On the first day of our inspection, 48 people were living at the service and on the second day, 49 people were present. People living at the service were older people, some of whom were living with dementia.

A registered manager was in place until 27 March 2018, when they left the service and de-registered. However, they returned to the service on the day of our inspection. The manager said they were taking up their previous position and would submit a registered manager application again. We will monitor this. 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.

Risks associated with people's needs had not been effectively assessed, planned for or monitored. Information to guide staff of how to manage risks lacked detail and did not reflect people's current needs. Where people experienced periods of heightened anxiety that affected their mood and behaviour, staff had limited information about the strategies to support people. Staff were aware of their responsibilities to protect people from abuse and avoidable harm. The provider was working with the local authority safeguarding team who were investigating safeguarding incidents and concerns.

Equipment used to reduce and manage some people's risks, were found to not be used effectively to mitigate risks. The systems in place to record, monitor and analyse accidents and incidents people had experienced had not been fully completed. This impacted on the provider having clear oversight and the ability to consider if lessons could be learnt to make improvements.

The deployment of staff required reviewing to ensure people's safety and individual needs were consistently met at all times. Safe staff recruitment procedures were in place and followed. Some shortfalls were identified in the management of medicines. Infection control and prevention measures were in place to reduce the risk of cross contamination.

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had not been fully adhered to meaning people's rights had not been fully protected. People's communication needs had not been considered when assessing people's mental capacity, and assessments lacked detail or had not been completed when required. Where people had conditions specified in their Deprivation of Liberty Safeguards authorisation, these had not been monitored.

The provider used recognised assessment tools when assessing people's needs. People's nutritional needs were assessed and referrals were made to external healthcare professionals, when concerns or changes occurred such as a change in a person's weight.

Staff received an induction, ongoing training and support.

Systems were in place to work with other organisations. The staff worked with external healthcare providers to meet people's health outcomes. Monitoring of wound care was found to not always be effectively managed. The design and layout of the building was not fully conductive to meeting the needs of all people that used the service.

Staff were inconsistent in their approach in providing people with dignified and respectful care. Additionally, there were inconsistencies in staff promoting choice. Relatives were positive that they were involved in their family member's care and treatment. People had information about, and received support to access independent advocacy services.

People's individual and diverse needs were not always met and respected. People were at risk of receiving inconsistent support, care plans did not provide an accurate or up to date description of their needs. The provider's complaint procedure had been made available for people that met their communication needs.

Opportunities for social activities and participation in meaningful occupation and stimulation were limited. End of life plans were not routinely completed but were in place for people who were at the end stage of their life. Some staff had received end of life training and plans were in place for all staff to receive this.

The systems and processes in place to check on quality and safety were found to be ineffective. The provider had failed to identify the shortfalls in the fundamental standards that were identified during this inspection. There was a lack of oversight, accountability and consistent leadership. Recent management changes had not been managed effectively or were communicated with people, relatives, representatives and staff.

During this inspection we found four breaches of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious 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?

Requires Improvement

The service was not consistently safe.

Risks associated with people's needs were either not assessed or information lacked details. Equipment to protect people against risks were not used safely. Staff were aware of safeguarding procedures.

Staff deployment required reviewing. Safe staff recruitment practices were followed.

Some shortfalls were identified in the management of medicines.

Prevention and control measures of infection control were in place.

Accidents and incidents were not effectively monitored and analysed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not fully protected under the Mental Capacity Act 2005. Deprivation of Liberty Safeguards were in place but conditions were not monitored.

People received support with eating and drinking needs and nutritional needs were assessed and planned for.

National best practice guidance was used in the form of recognised assessment tools to assess people's needs.

Staff received an induction, training and support but staff required additional dementia awareness training.

Systems were in place to work with other organisations. People's health care needs were assessed but not always effectively monitored.

The design and layout of the building did not fully meet the

needs of people living with dementia.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not consistently treated with dignity and respect.

Choice, involvement and the promotion of independence was variable. People had access to information about independent advocacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not consistently receive care and treatment that was individual and specific to them or fully met their diverse needs.

People had access to the provider's complaint procedure and this was presented in a format that met people's needs.

Is the service well-led?

Inadequate

The service was not well-led.

There had been a lack of oversight of the service and changes within the leadership of the service, had not been effectively managed or had been transparent.

The provider's audits and checks had failed to identify concerns and shortfalls in the fundamental standards identified during this inspection.

Belle Vue Lodge

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.

The inspection was prompted in part due to concerns relating to an increase in safeguarding notifications. We had also received information from local commissioners raising concerns about how risks, quality and safety were managed. At the time of this inspection, the local safeguarding team were undertaking some safeguarding investigations. Both the local authority and local clinical commissioning group had suspended their contract with the provider.

This was a comprehensive inspection that took place on 2 and 3 May 2018 and was unannounced. The inspection team consisted of three inspectors and an assistant inspector.

On this occasion we did not ask the provider to send their provider information return (PIR) prior to the inspection. 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. However, at the inspection we offered the manager and management team the opportunity to share information they felt relevant with us.

The inspection was also informed by other information we had received from and about the service. This included previous inspection reports and statutory notifications. A notification is information about important events, which the provider is required to send us by law.

On the day of the inspection, we spoke with seven people who used the service and nine visiting relatives for their views. We also observed care and support in communal areas of the service and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection, we spoke with the manager, compliance manager, clinical lead, training manager (who had also been the acting manager), two nurses, an agency nurse, a nursing assistant, the head cook,

activity coordinator, nine care staff, the housekeeper and maintenance person. We looked at all or parts of the care records of 11people, along with other records relevant to the running of the service. This included how people were supported with their medicines, quality assurance audits, training information for staff and recruitment and deployment of staff, meeting minutes, policies, procedures and arrangements for managing complaints.

We also spoke with a visiting gas fitter and two visiting health care professionals. This was an occupational therapist in the community dementia outreach team and an occupational therapist from the community falls and rehabilitation team. We also spoke with a person who visited the service regularly and provided spiritual support to people.

Requires Improvement

Is the service safe?

Our findings

People did not always receive safe care and treatment. Risks associated with people's needs had not always been effectively managed to reduce known risks. People were at risk of choking. During our inspection, we observed a person was put at risk of choking on multiple occasions because staff were unaware of their needs. The person had an eating and drinking assessment completed by an external healthcare professional the day of the first incident occurred. Whilst the person's mini care plan, which staff used for guidance and instruction, had not been updated, an alert was in the care file that staff had access to. This advised of the risk and action required to reduce the risk of choking, including a fork mashable diet and direct supervision when eating. In the afternoon of the first day of our inspection, a staff member gave the person toast. They did not remain with the person. Although the person did not eat the toast, it was 10 minutes before a staff member realised the mistake and removed the toast.

We saw this same person choked on their main meal on the second day of our inspection requiring emergency medical support. Although the food was mashed they were not closely supervised. When the person began to cough a staff member then went and sat beside the person. The person continued to cough and two nurses came to assist. They were unsuccessful in reducing the persons coughing and called the paramedics due to concerns about choking. Later the same day we found the person had a thickened drink as required, a domino board piece was found in the drinking beaker. We showed a staff member present what we found and removed the drink. This placed the person at risk of serious harm.

Staff did not have sufficient guidance to enable them to safely manage risks associated with people eating and drinking. During the inspection, we regularly heard staff asking each other what diets people were on. This was because there was no written guidance for staff. This was a concern because staff should have confidently have known this information. There was a risk that reliance on other staff without up to date care plans and risk assessments could put people at risk.

Information about people's dietary needs, including who was at risk of choking, was not readily available to care or catering staff. While the head cook said the information was in the kitchen, they could not locate it and had to go to the office for the information. On viewing the 'residents' diet summary' record, we found this did not include who was at risk of choking and some information was incorrect. For example, one person's care records had a letter dated 7 March 2018 from an external healthcare professional, which advised staff of the support they required to reduce the risk of them choking, this included a soft diet and staff supervision. However, the residents' diet summary recorded the person was on a normal diet, the professional advice was also not recorded in their mini care plan. Although the information was in their main care plan this was not used by staff and posed the risk there would be an inconsistent approach by staff when supporting this person.

Snack boxes were provided to encourage people to eat. Some staff raised concerns that snacks provided were not always appropriate for people at risk of choking. We discussed this with the manager who followed this up with staff immediately.

In addition to the above, several staff commented that meals provided were not always easily mashed. Staff were responsible for ensuring food was served in the correct texture and it is of concern, given the limited knowledge of staff, that the kitchen did not fully prepare people's to the required texture food in advance of it being served. This further increased the risk of harm.

Equipment designed to reduce risks to people was not used correctly and this placed people at risk of harm. We were concerned to find mattresses unplugged and there was no instruction as to what the inflation requirements were. This is variable dependent on people's individual weight. Staff told us they had been instructed by a member of the management team to plug the mattresses in an hour before the person went to bed. We were concerned that as people could return to their bed at any time, without the mattress inflated and at the correct settings, this could have had a negative impact on their skin. Some people had sensor mats due to the risk of falling, these alerted staff of when the person was walking independently. These were also found to be unplugged. The manager told us they would introduce daily checks to be completed twice a day to ensure this equipment was plugged in. In addition, they agreed to provide staff with clear information about mattress settings.

All of the above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had personal evacuation plans that advised staff of their support needs in the event of them needing to evacuate the building. This information did not accurately reflect people's current needs and placed them at risk of not getting the support they needed in the event of an emergency. The manager updated this information during the inspection.

The fire service had conducted an audit of fire safety in April 2018 and made several recommendations that required completing to show compliance with fire standards and safety. The maintenance person gave examples of the action they had taken. However, we noted the current action plan did not include works that still required action. This meant there was a risk that additional works required may not be completed. Staff had been trained in health and safety and how to respond if there was a fire in the service.

On one unit, we saw a bottle of perfume and an open can of drink was in reach of people. This was a concern because most people were living with dementia and may not have been aware of the potential harm if they had digested these items. Some people were also a high choke risk. We informed the manager of this concern and when we checked later these items had been removed.

Some people told us of concerns they had about how some staff met their needs. We reported this to the local authority safeguarding team and shared it with the manager, who took immediate action to investigate. We were aware that the local authority were conducting other safeguarding investigations at the time of our inspection.

Relatives told us they felt their family member was safe living at Belle Vue Lodge. One relative said, "My family member is quite safe, I check them every day, I do assist with personal care and check their body. The staff are now better at recording any indication of possible bruises."

Staff gave examples, which demonstrated they were aware of their role and responsibility to protect people from avoidable harm including discrimination. This included how to raise any concerns and included internal and external procedures. The staff were able to tell us the different types of abuse and what signs and symptoms people might have if they were experiencing abuse, such as unexplained bruising and a change in their usual behaviour.

Recent safeguarding concerns had led to an increased awareness of risk from staff. We observed staff discussions about a person's near miss for a fall. A staff member recorded the incident in the person's daily records. People did not experience undue restriction on their freedom. For example, people were able to walk around the unit and had a choice of where they spent their time. We saw staff supported people to access other areas of the service and the garden.

Some people living with dementia experienced periods of heightened anxiety that affected their mood and behaviour. Care plans to instruct staff of the support required during these times lacked specific information and detail in places. There was limited information of the behavioural strategies to use to calm a person such as diversional techniques. For example, one person's care plan stated 'at times can be verbally aggressive towards others' and that 'distraction techniques should be used'. However, there was no description to advise staff of what action to take. Recorded information is important for new and agency staff to understand people's needs and for staff to provide consistent care. Without clear guidance for staff, meant people were at risk of inconsistent and potentially unsafe support.

However, we found staff were knowledgeable about people's needs and the support required to reduce anxieties that could affect their behaviour and wellbeing. We saw how staff supported people at times of heightened agitation that had a calming influence, such as talking with the person giving reassurance and using distraction techniques.

Improvements were required to ensure staff were deployed effectively to meet people's needs and ensure their safety. A relative told us that staffing levels had improved. This relative said, "There have not always been enough staff, but there are now. There are always two staff on [relations] unit. If one rings in sick then staff lose their breaks to make sure it is all covered. There is less agency now too, which is good. It has got much better here with staff in the last year."

Some staff raised concerns that there was insufficient staff available or there was a delay in staff responding to requests for assistance. A staff member said, "This means situations escalate if not dealt with quickly. This has led to incidents and accidents in the past, involving service user's losing their balance and falling during an altercation between them." Some felt that staff were not always placed appropriately, according to their experience and capability of dealing with behaviours that could be challenging.

There were six individual units over three floors. This made it difficult for staff to easily move from one area to another when support was needed. We saw that on each unit an intercom was used to call for assistance. During the inspection, we noted several occasions when staff called for assistance but there was a delay of several minutes in staff responding. The manager told us how they assessed and monitored people's dependency needs that informed them of staff level requirements. Some people required one to one staff to keep them safe and we saw this was provided. We concluded a review of people's current dependency needs and deployment of staff were required to ensure staffing levels were sufficient in keeping people safe. Following our inspection, the local authority made us aware of further concerns about staffing at night. At the time of writing this report this was being reviewed by the provider.

People were supported by staff who had been through the required recruitment checks as to their suitability to provide safe care and support. These included references and criminal record checks. Recruitment files showed the necessary recruitment checks had been carried out. Staff also confirmed they commenced employment after checks had been completed.

We identified there were some shortfalls in the management of medicines. For example, handwritten entries on medicine administration records (MAR) were not always signed by two staff. This is best practice

guidance to ensure no mistakes are made during transcribing. The opening of topical creams were not dated, this is required to ensure they are not used after the expiry period. Transdermal patches used to deliver a specific dose of medicine through the skin and into the blood stream, require a body map rotation chart for site application. The MAR for one person confirmed the patch had been applied but the rotation chart was not completed correctly. This meant it was difficult to know if the patch had been rotated as required to reduce skin irritation. Only one of the three medicines cabinets had been secured to the wall using the tethers provided. It is a requirement that cabinets are secured when not in use. The manager told us they had identified some staff required medicines refresher and competency checks completing as these had expired. The manager arranged for these actions to be completed with immediate effect.

The local clinical commissioning group had completed an infection control audit at the service in September 2017. This audit identified some improvements were required in infection control measures including cleanliness. We spoke with the infection control lead who told us the required actions had been completed. Whilst they were unable to provide an action plan to confirm what action had been taken and when, from viewing the audit report our observations found the required action had been completed.

A housekeeper told us of the systems in place to meet cleaning standards and best practice guidance in infection control prevention. We found these processes were in place as described and the environment was clean. We saw housekeeping staff cleaning throughout the inspection, they had the required cleaning equipment and were organised. Cleaning schedules confirmed what cleaning had been completed. However, the cleaning schedules found one staff member had signed for the whole week ahead. The staff member said this was an error and removed the cleaning schedule.

There were systems in place to record, report and analyse accidents and incidents. However, incident reports were not fully completed by staff. There had been no analysis for March and April 2018 of accidents and incidents including falls. This meant the systems and processes in place to evaluate and learn from incidents was not effectively managed.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 20015 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff demonstrated a basic understanding of the principles of MCA and DoLS. Staff knew that they would need to speak to someone more senior if they were unsure about someone's capacity in relation to risk and whether they needed to act in the person's best interest.

We saw some examples of mental capacity assessments and best interest decisions that had been completed in areas such as personal care. However, assessments in other areas such as medicines and the use of sensor equipment to monitor people had not been completed. Assessments were variable in the quality of detail. Several assessments had no specific decision recorded. Some people's first language was not English; it was not clear how capacity assessments and DoLS applications to restrict people's freedom and liberty had been approached. There were no examples that people's communication needs had been considered. This meant there was a risk people's rights under the Act may not be respected.

At the time of the inspection, 14 people had an authorisation in place to restrict them of their freedom and liberty, 11 of these people had conditions imposed that the provider was required to meet and monitor. These were mainly in relation to activities. We asked the manager to provide evidence of how these conditions were being met. The manager told us they were unable to provide this information, but would address this. This meant we could not be assured people were receiving opportunities to engage in activities as described in the condition of their authorisation.

All of the above information was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received a mixed response from people about the quality of food available. One person said, "Food which should be soft and easy to eat, is hard. Hash browns and peach crumble have both been inedible because they were too hard." However, another person said, "I enjoyed my meal today I went back for more." Several people raised concerns about the food not being hot when served. A heated trolley was used to take food to the three floors but was not plugged in during transportation; this could impact on the food temperature.

Staff used person centred ways of encouraging people to eat. One staff member supported a person to eat

by walking with them while they ate a sandwich because they did not want to sit down. Another staff member used a therapy doll to encourage a person with their eating and drinking. People responded well to these methods. Some people required assistance with their meals and drinks. We saw staff engaged and supported people well, communicating in a calm, softly spoken and patient way. People were given time to eat and some staff supported people to walk away from the living area during mealtimes if they expressed a wish to.

People's nutritional needs had been assessed and planned for. People's food and fluid intake was recorded and monitored to ensure people were eating and drinking sufficiently. People's weights were also monitored and action was taken if concerns were identified such a referral to the GP.

The provider used best practice guidance and care was delivered in line with current legislation. For example, the provider used recognised assessment tools used in the assessment and monitoring of pain referred to as, The Abby Pain Scale. Some staff had attended end of life training in The National Gold Standards Framework in end of life care. Assessment of people's needs included the protected characteristics under the Equality Act and these were considered in people's care plans. For example, people's needs in relation to any disability were identified. The environment and equipment provided helped to ensure people did not experience any discrimination.

Relatives were positive that staff understood their family member's needs. One relative said, "It feels like the staff know what they are doing and have the training they need." This relative added, "They arranged some training a while back specifically around [relations] needs from the dementia team which was great."

We observed a staff handover from night to day staff on both inspection days and found each person was discussed as to any changes in needs, appointments or action required. However, some staff reported that handover information sometimes lacked detail and was not organised well.

Staff confirmed they had access to the training they required to undertake their role. One staff member said, "I feel the training has helped a lot I can deal with challenging behaviour and I know how to interact with people." Another staff member said, "The training is really good, some of the best I've had."

Several staff told us that whilst they had received dementia awareness training this was general and could be more specific. We observed staff engaging and communicating with people throughout the inspection.

The staff training plan and staff files, confirmed staff had received training in the areas the provider had identified as required. Where refresher training was due, plans were in place for staff to receive this. Staff received opportunities to discuss their work, training and development needs.

Systems were in place to work with other organisations. The service used the 'red bag' scheme this is an NHS initiative to improve communication between care homes and hospitals. If a person was required to attend hospital, the red bag contained information about the person to support with their ongoing care and treatment.

People's health care needs were assessed, monitored and reviewed. Relatives were confident that healthcare needs were known and understood. One relative said, "Health needs are known by the nurses. The palliative nurse visits every week and communication about changes with health is good." Another relative said, "The GP is called when needed. We are waiting for a dentist appointment now and the dementia team visit every three months." A third relative said, "The new nurse contacted me immediately about a lump on my family member's back, they told me about it and that they would get the doctors

involved, that type of contact did not happen before."

People's care records included NHS factsheets about particular health conditions to support staff with their understanding and awareness. This included alerts about pressure ulcer stages. We saw examples in people's care records of how staff worked with external healthcare professionals. We spoke with two external healthcare professionals who told us that referrals were made in a timely manner and overall recommendations were followed. One professional said, "There are some people with very complex needs and the staff work well in meeting these."

We looked at how wound care was managed. We identified some gaps in records when wounds should have been reviewed and photographs were not routinely used as a method to monitor healing. The clinical nursing file about people's current clinical risks and how these were managed was not easy to follow. However, when speaking with the clinical lead and nursing staff they were knowledgeable about people's needs, risks and actions being taken to meet people's needs. During the inspection, several people attended hospital outpatient appointments. These appointments had been planned for and staff were organised to provide support.

Each unit had a communal area with a dining table, space was limited and the environment could become noisy. This was a concern because people living with dementia are particularly sensitive to environmental factors, which can affect their emotional well-being. Some attempts had been made to make the environment homely. The corridors had sensory activities on the walls, things which could be touched and used to engage people that walk around. However, we did not see people being introduced to them and shown how to use them. A communal dining and seating area was available in the reception that people were supported to use, this provided a change of environment. People also had access to a safe and secure garden with tables and chairs. Signage was used to support people with orientation, most bedrooms had the name of the person and either a photo or images of things that were important them on their door.

Requires Improvement

Is the service caring?

Our findings

People received an inconsistent level of care in relation to dignity and respect. Most people relied on staff for all their care needs including personal care, concerns were identified in how these needs were met. For example, the day before our inspection a visiting health professional had completed body checks on people and identified concerns with people's foot care. This included dirty feet and nails, toenails needed cutting and skin creamed, and some concerns were identified with people's footwear. We also noted a person who was wearing open sandals had dirty toenails. This meant people were not receiving appropriate personal care and attention and did not respect their dignity.

Staff were also inconsistent in how they met people's comfort needs. For example, we saw a person asked for a different blanket at breakfast time because the one they had, was too big and heavy for their small frame. The person voiced how uncomfortable it was. A staff member did not look but told the person they would find a smaller, lighter blanket. At late afternoon this had still not been done. The person was sitting forward on their chair because the blanket was so bulky. The staff member stated that they had not changed the blanket because they had been "waylaid" between breakfast and teatime. We intervened to find the person a more suitable blanket, which was found very close to the lounge where they were sitting.

They way in which staff communicated with people did not always show dignity and respect. For example, staff would regularly drift from speaking to the person by name to then referring to people as 'them' or non-personal names for example, by the health conditions they had.

A person who used the service was positive about the staff and the care they received. This person said, "I am happy living here and I like the care staff." Relatives overall were positive about the approach of staff. One relative said, "95% of staff are caring and 5% are not because they lack knowledge and don't interact with the service users." Another relative told us they were happy with their family members care and support at Belle Vue Lodge. They said, "Staff know [relations] needs, they know how to respond to them. They give them attention and they act on their requests. The care is excellent." A third relative said, "This place does have good carers' who pick up on details. They know my family member very well and they are settled."

In contrast with the above, we also saw good examples where staff supported people using a caring and respectful approach. For example, when a person became agitated a staff member took them a walk around the building and garden to distract and calm them. A staff member was seen to use pictures of famous film stars as an approach to distract another person who had become unsettled affecting their mood and behaviour. Some staff communicated with people by using therapy dolls that gave people comfort. Research shows (Dementia UK) the use of dolls can bring great benefit to some people living with dementia. One staff member used a magic trick to distract and entertain a person who was shouting. The interaction promoted the person's well-being and maintained a calm environment for the other people.

We saw some positive examples of staff interacting with relatives. We also saw how a staff member on arrival to start their shift, immediately went to a person and spoke about the activity happening the next day.

Advocacy information was available to people. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known. A person who used the service gave an example of how an advocate had supported them. The manager also gave an example of how a person had been supported by an independent advocate. This meant people were supported when they needed independent advocacy support.

Relatives told us they felt their family member was involved as fully as possible in their care and that they were consulted and involved too. One relative said, "They [staff] really understand [relations] needs and moods, the nonverbal signals and they react accordingly. Like in the mornings, slowly waking [relation] up, little by little, opening the curtains, coming back a while later with a drink and so on until they is ready to get up. All at their own pace. [Relation] leads on their own care."

Staff had received training in dignity and respect and they had time to spend with people. The rota was planned to meet people's individual needs. For example, a person attended an outpatient's appointment regularly for treatment and a staff member was allocated to attend with the person. Overall, staff were positive about their work. One staff member said, "It's more about the job, than the money, I enjoy looking after the residents." Another staff member said, "My duty is to provide the best care I can, I love my job."

People's care records included instructions to staff about promoting people's dignity and respect when providing care and support. Staff were knowledgeable about people's preferences and routines.

We saw examples where people were encouraged in activities that promoted independence. For example, we saw several times when people were encouraged to assist staff with daily tasks such as returning the drinks trolley back to the kitchen and people involved in folding laundry. A staff member said, "There are two people who like washing and they have assisted us with doing the washing and hanging clothes out."

People's information was treated confidentially and was managed in line with the Data Protection Act. For example, information was stored securely and staff were aware of respecting people's personal information.

There were no undue restrictions in place about people receiving visitors; relatives confirmed they could visit unannounced. One relative had brought their family member's dogs onto to visit them, which was important to the person and respected by staff.

Requires Improvement

Is the service responsive?

Our findings

Before people moved to live at Belle Vue Lodge, a pre-assessment of their needs was completed with them and or their relative/ representative. Care plans were then developed and used to inform staff of people's holistic needs, including consideration of their diverse needs and lifestyle preferences. For example, people's ethnicity, sexuality, religion and cultural needs, preferences and routines were recorded. This was to inform staff of people's support needs and what was important to them, to enable staff to provide people with person centred care and treatment.

Care files were structured to provide staff with information to ensure personalised care but did not contain all relevant information, with an over reliance on verbal communication amongst staff. A relative said, "I look at daily records they are sometimes not as accurate and do not record all that has happened."

Some people told us their response to requests for support was variable. One person said, "It depends who you tell but it'll get done in the end". This person also told us they had to wait for things such as the hoist. This person said, "Everybody is hunting for it. There aren't always enough staff to help people when they want it because people are on their breaks or watching other floors."

We found mini care plans which staff used to direct care and treatment, were not up to date or reflective of people's current needs. Monthly evaluations of care plans were not effective, as they did not accurately reflect changes in people's needs. For example, one person's falls management care plan had not been updated to show the person's increased dependency needs. We saw staff did not always follow care plan information. One person with mobility needs had had their needs assessed by an external healthcare professional but staff did not follow instructions. For example, the health professional had advised the person should only use their bedroom en-suite due to being able to accommodate their walking frame. We spoke to a staff member who was unaware of this and told us they had supported the person in a communal toilet. On viewing the toilet, we noted there was no grab rails to assist the person to transfer and no room for their walking frame. This meant staff were not following instructions of how to meet people's individual needs and potentially placed them at risk of harm.

On the second day of the inspection a new staff member was unaware that one person could not use their wheelchair footrest because of their physical restrictions until they were informed by another staff member. These examples demonstrate people did not receive a responsive and consistent approach to their needs.

We also found people did not consistently receive care and treatment that was responsive to their individual preferences and diverse needs. For example, people's choice and preferences in relation to meals did not consider their cultural and religious preferences. One person's care plan stated they preferred specific cultural foods. However, these meal choices were not available on the menu or available. A staff member told us about two other people who had particular food preferences in relation to their cultural needs and preferences, but this need was not met. This staff member said, "People's diverse and cultural needs are not respected or considered." We discussed this with the manager who agreed the menu would be reviewed to ensure it reflected people's preferences.

A written menu was displayed that advised what the choice of meals were. However, this was not presented in any other format such as pictures to support people with communication needs or if English was not their first language. The manager told us they would review the menu and ensure it was provided in alternative formats to support people's communication needs.

People's meal requests were not consistently respected or acted upon. For example, we saw a person was offered a choice of breakfast between 10am and 10.25am. The person asked for a bacon sandwich. The staff member contacted the kitchen with this request but the kitchen stated there was no bacon, so the person was served an alternative. However, at 11am another person requested a bacon sandwich and was provided with this. We spoke to the head cook who said that bacon was available but they had declined the person a bacon sandwich because of the time and that lunch would be served soon. This did not respect the person's right to make choices and direct their own care and support. We informed the manager of this information who took immediate action to address this concern with staff.

At teatime, one person who required a soft diet did not like the sandwiches available and requested an alternative. Staff said that it was not available without making any enquiries. The person was unable to have the other sandwiches available because they were not suitable for their dietary needs. The person was given a piece of cake as an alternative without discussing it with them first.

We noted one person had a letter from an external health professional dated March 2018 that stated the person required milkshake drinks in addition to snacks in-between meals. We noted on the morning of the first day of our inspection, a person was offered a drink but no snack. When we asked a staff member about this, they replied that the person did not need a snack, because they had eaten their breakfast and had had a supplement drink. This did not match the external healthcare recommendations. Neither was the person offered a choice if they wanted a snack, there was an assumption by the member of staff they were not hungry.

Some people's first language was not English and whilst there had been some consideration to this, people received inconsistent support. Although some documentation had been provided in an alternative language we observed people's communication needs were not met in other areas. For example, a person whose first language was not English could not verbally communicate, their care records informed staff to use prompt cards to help facilitate communication. We asked a member of staff to show us these communication cards but they were unable to locate them. We did not see staff use these cards for the duration of our two day inspection. We discussed this with the manager who was familiar with this person's communication needs and agreed to follow this up with staff.

Some relatives told us that they felt activities could be improved upon. One relative said, "I think they [staff] could still be doing more, even doing something that other people could watch if they could not join in themselves."

During the inspection, there were limited activities available for people; staff were inconsistent in their approach in supporting and encouraging people to participate in activities. For example, we saw some staff supported people to participate in conversations, games, table top activities and walks in and around the service. On one unit, a staff member was engaged in an activity with a person doing a jigsaw; however, the other people in present were not involved in doing any activities. We also saw examples where staff had limited engagement with people, gave no choice of what was on the television and had social conversations amongst each other to the exclusion of people who used the service.

All of the above information was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

An activity coordinator was new in post and told us they were developing an activity plan, they demonstrated a commitment in wanting to improve activities, stimulation and occupation and had a good understanding of the needs of people living with dementia.

Positive feedback was received from a relative about how their family member was supported with their religious needs. This relative said, "They (staff) always invite [relation] down to the religious community services but they often refuse. [Relation] will put their hands together to pray, and when they do this the staff always encourage them to say their prayers." We spoke with a visitor from the community who regularly visited people and provided spiritual care. They told us staff supported people to attend these services.

Relatives told us they were involved in discussions and decisions about their family member's care. One relative clearly knew what was recorded in their family member's care plans and they told us they had input in putting it together.

We saw some positive examples of staff being responsive to people's needs. For example, a staff member responded to a person who was standing up but unable to verbalise their needs or wishes. They tried several ways to support the person for example, they passed them their walking frame; they held the person's hands to make sure they were safe. They asked the person if they wanted help with something such as did they want more food, did they need to use the toilet or did they want to have a walk. They persevered until the person had their needs met.

The provider had taken some considered and action in meeting the Accessible Information Standard. This standard expects providers to have assessed and met people's communication needs, relating to a person's disability, impairment or sensory loss. For example, people had access to the provider's complaint procedure and this was presented in an easy read format to support people's needs. It had also been provided in an alternative language. A photograph of the manager was also included to support people to know who was responsible for investigating complaints. People's communication needs had been assessed.

Relatives told us they felt confident to raise any complaint or concerns and that this would be responded to. One relative said, "If we complained about something the registered manager would always do something about it." Another relative said, "I can always talk to the manager about anything. She listens and always resolves it."

The complaints log showed there had been one complaint since out last inspection, which had been responded to in line with the provider's complaint procedure.

People's end of life wishes had not always been planned for. However, where people were at the end stage of their life, end of life care plans had been developed with the person and or their relative / representative. A relative told us, "I'm happy how my [relation] is being cared for at the end stage of their life. Staff make sure they are well cared for and comfortable and they are working with the palliative nurse to make sure they are pain free." Some nursing staff had received end of life training and plans were in place for all staff to receive this training. We saw staff were attentive to people's needs and end of life care plans provided staff with important information about how to support people at the end stage of their life.

Inadequate

Is the service well-led?

Our findings

The systems and processes in place to assess monitor and review risks, safety and quality were found to be ineffective. Whilst the provider had an ongoing action plan they had developed to show the areas they had identified needed improving, the concerns identified during our inspection had not been identified by these audits and checks. The outcomes of audits completed by external organisations such as the fire and rescue service and infection control were not on the provider's action plan. This meant people's safety had been compromised.

The manager's monthly monitoring system of accidents and falls analysis showed there was no analysis for March and April 2018. A review of accident and incident records showed these were not completed fully. For example, it was not always recorded what action had been taken to reduce the likelihood of reoccurrence. A review of the person's care plan and risk assessment had not been completed and referrals to external healthcare professionals were not always recorded. Post incident observations were not recorded to show people's health and well-being had been monitored. This failure to analyse accidents and incidents meant that opportunities may have been missed, to identify ways of preventing future incidents and exposed people to the unnecessary risk of potential harm and injury.

Recording charts used to monitor incidents of behaviour that could pose a risk to the person and others, were found to be insufficiently completed to enable a clear understanding of what had occurred and what support may have been required to reduce further reoccurrence.

Risks associated to people's needs, in particular choke risks, had not always been effectively assessed and planned for. This put people at risk of avoidable harm. People's care plans to inform staff of how to meet their needs were found to lack detail in places or was not up to date to reflect current needs. This put people at risk of receiving unsafe and inconsistent care and treatment.

The governance of the service in recent months had been ineffective, with inconsistent leadership and oversight. Recent changes with the management of the service had not been communicated with people and their relatives / representatives and staff. This meant there was a lack of transparency. A relative told us, "There is a lack of communication from the provider's head office to explain what is going on I know the registered manager was trying to get everything right before they left the first time but we did not know the registered manager was going."

As part of the provider's internal quality assurance checks annual satisfaction surveys were sent to people who used the service and relatives, the outcome of the findings were shared with people on a notice board in the reception area. Resident and relative meetings were also arranged as an additional method for people to feedback their opinions about the service, but these were not effective in addressing concerns. A relative said, "The relatives meetings are monthly, it is a vocal group. We are trying to get something done about a bathroom at the service. The rooms are all en-suite, but there is no option for people to have a bath." Another relative said, "There were two recent meetings to discuss issues at the service. I heard by word of mouth about the meetings. The first meeting had staff there too which was inappropriate due to issues

discussed about safeguarding and standard of care." A third relative said, "Things coming out of the meetings have not been followed through. There was a staffing issue when people needed more assistance to avoid people being left. There were inaccurate records keeping. The staff needed to work more as a team. There is a problem of losing things at the home, for example issues with laundry being lost. The provider has not followed through on actions to resolve these problems."

All of the above information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above, the manager was very responsive to the concerns raised and addressed some issues we identified immediately. They returned to the service on the day of our inspection and confirmed there had been a number of management changes recently however were committed in addressing the shortfalls we had identified.

Staff were clear about their role and responsibilities including the reporting structure and process to share information, including raising issues and concerns. Staff told us they felt supported but expressed some concerns, about internal communication systems and processes in place that they felt could be improved upon. This included the exchange of information, being informed of outcomes to information raised and in receiving feedback about positive practice and performance. Some staff raised concerns about the layout of the building that meant it was not easy for the management team to consistently monitor the quality of care and treatment across all areas of the service.

The staff worked with external healthcare professionals to deliver positive outcomes for people. The provider was working with the local authority and local clinical commissioning group and safeguarding team to make improvements.

The provider had met their registration regulatory requirements because they had notified CQC of incidents they are legally required to do. It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed their most recent rating in the service and on their website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people did not reflect their individual needs and preferences. 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The care and treatment of people did not reflect their individual needs and preferences. 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's needs had not been fully assessed. Regulation 12 (1)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the quality and safety of the service were not effective. Systems place to record and investigate incidents which posed a risk to the health and wellbeing of people who used the service were ineffective. Contemporaneous care records were not always completed to show the care and treatment provided. 17 (1)

The enforcement action we took:

A warning notice was issued