Belle Vue Healthcare Limited

Bellevue Healthcare Limited

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**

Summary of findings

Overall summary

We inspected Bellevue Healthcare Limited on 5 and 16 September 2016. This was an unannounced inspection which meant staff and registered provider on each occasion did not know we would be visiting.

At the last comprehensive inspection completed on 21 March, 5 and 18 April 2016 we judged the home to be rated as inadequate and found multiple breaches of our regulations. The service had been placed into serious concerns protocol with the local authority in March 2016 and at the time of this inspection that remained the case. The service was entered into this protocol because of an increased number of safeguarding alerts made by external health professionals. The professionals involved in the serious concerns protocol had significant concerns about the registered provider's ability to provide safe care and support to people. An embargo was put in place which meant that nobody new could move into the service.

We carried out a further inspection on 12 May 2016 because of growing concerns about people's safety. We found that although the risks had not increased they still remained around ensuring people received safe care and treatment. People were not placed at any greater risks from staff failing to administer medication in line with their prescriptions and were receiving adequate food and fluid. However, when people lost weight, we found staff were still failing to ensure referrals to dieticians were consistently made.

This latest inspection was completed because concerns were still being identified and we wanted to make sure people were safe living at the service. We also wanted to make sure the registered provider was taking action to address the concerns which we had identified during the last two inspections completed in April 2016 and May 2016.

Bellevue Healthcare Limited is registered to provide care and support to 102 people. At the time of our inspection there were 52 people using the service and 97 staff employed. There were three units at the service which provided care and support to people living with a dementia, people who required nursing care and young adults living with a physical disability.

Bellevue Healthcare Limited was registered with the Commission in 2001. A registered manager was in place until 2014 when the registered manager retired. There had been three managers since then however none applied to become registered manager. A new manager is now in post and they have started the process to become registered manager. 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.

Not having a registered manager is a breach of the registered provider's conditions of registration. Following the inspection completed in April 2016 we issued a fixed penalty notice for this matter and the registered provider paid the £4000 fine in order to deal with this breach.

We also made the registered provider aware that they were failing to notify us of incidents and deaths, which is a breach of the Care Quality Commission (Registration) regulations 2009. We are currently dealing with this matter outside of the inspection process.

On 5 September 2016 we identified that four people were grossly underweight and all had Body Mass Indicators (BMI) of below 18. This shows that people are at risk of being malnourished and developing a compromised immune function; respiratory disease; digestive diseases; cancer and osteoporosis. One person had a BMI of 12, which placed them at very high risk of developing life threatening health conditions. Despite referring people to dieticians in July 2016 the staff had not recognised that people continued to lose weight and that their BMI were extremely low so had not got back in touch with the dieticians.

Where safeguarding alerts established that malnutrition or dehydration had occurred, there was no evidence to show that the service had taken action to reduce the risk of the incidents re-occurring. Also when people's nutritional supplements had not been received in a timely fashion the staff had not contacted the GP or dietician to request they were delivered. This had led to people not receiving the required supplements for over a month. In the interim these people continued to lose weight.
Food and fluid balance charts had not always been completed. Records showed that people consumed less fluid than were specified in their care plans. There was no evidence to suggest that people were offered snacks outside of meal times or that people at increased risk of malnutrition were offered nutritional supplements.

We found that staff were not identifying the development of pressure ulcers clearly. This meant care plans had not been produced to detail how these were being treated or the action they needed to take if the pressure ulcer changed or became infected. Staff had not been accurately identifying and recording when people had pressure ulcers. Referrals had not been carried out in a timely manner.

Following our visit on the 5 September 2016 we wrote to the registered provider to make them aware of our serious concerns about people's welfare and asked them to take immediate action to ensure people's health was not compromised.

On 16 September we visited to check that the action the registered provider had said would be taken had occurred. We found that they had compiled a list of people's current weight and people who had wounds. They had contacted GPs and dieticians for all people who were found to have compromised weights and with wounds. Also they had ensured the cook was aware of people who were losing weight or had a low weight so the cook could provide these people fortified food. Additional supplies of fortified foods were provided throughout the day and the registered provider checked that people were eating. Although improved the records still did not fully evidence the actions staff were taking when providing care and treatment for people.

We also found that one of the registered provider's directors, who is a retired GP and without a license to practice had been completing and signing 'Do not attempt cardio-pulmonary resuscitation (DNACPR), as senior consultant. This is a breach of the Medical Act 1983. We found that some people's DNACPR certificate stated 'general frailty' rather than a specific clinical condition, which does not following General Medical Council (GMC) code of practice.

We judged this to be a major risk and in line with our enforcement policy are taking action to deal with this issue, which we will report on once completed.

The registered provider visited the service each day and we observed them carrying out checks of the

service, however they had not recorded any of their visits as part of quality assurance processes. This meant we could not see what checks were being carried out.

The service had started to introduce a small number of audits. However there were gaps within these. Where actions for improvement had been identified, no action plan had been produced and there was no evidence of any action taken following the audit.

The service had started to make safeguarding alerts, however these were limited to incidents between people using the service. Safeguarding alerts for people at risk of malnutrition, dehydration and pressure sores had not been made. However, safeguarding alerts regarding these incidents had been made by visiting health and social care professionals. Since 27 July 2016 a total of five safeguarding alerts had been up-held for abuse including ones for neglect because malnourishment and dehydration had occurred.

We found that risk assessments were not always in place for people who needed them. These included people at risk of falls, and those using calls bells and lap belts. Some risk assessments were not person-centred and did not always contain accurate information.

Core care plans had been introduced at the service. This meant people had care plans in place even when no care needs had been identified. We found care plans were generic rather than person-centred and did not accurately reflect people's actual care needs and the risks in place.

There were gaps in recruitment records which meant that it was unclear about how the registered provider decided applicants were suitable to be employed. A recruitment exercise was taking place during our inspection. Two candidates were offered positions as carer on the day and were asked to start one week later. We were concerned about this because we could not been sure if two checked references and a Disclosure and Barring Services check for each person could be obtained within this time frame.

Care records contained conflicting information about people's capacity. In some care records, there was evidence to suggest people had capacity and similarly did not have capacity. Where people lacked capacity there was no evidence of any 'best interest' decisions making.

Care plans had not been signed by the people they related to. This meant we did not know if people had been involved in their care plans or if they had agreed to them. Care plans were also required to be signed by people who lacked capacity. There was no evidence in the care records where people lacked capacity to show whether their relative had Lasting Power of Attorney for care and welfare, yet they were being asked to agree to and sign to care plans.

We found that restrictive practices in place without evidence of best interest decision making. For example, we found some people were in bed with minimal clothes on, such as an incontinence pad and protective pants . In one care plan this was recorded as the person's choice but when we visited this person we found they could not communicate.

The service had started to make improvements to the management of medicines, however, we found that further improvements were required. Insulin management for people with unstable diabetes was not clear because care records and medicine administration records (MAR) were difficult to follow. There were gaps in the topical medicine administration records (TMAR).The topical creams identified in care plans were not accurately reflected in people's TMARs.

A new manager and clinical team lead were in place. Some staff told us they felt able to approach them and

visible management was regularly in place. Some night staff were concerned because they had not met the manager who had been in place for three weeks.

We found the provider was continuing to breach the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified during inspection on 21 March, 5 and 18 April 2016. These breaches related to safe care and treatment, dignity, consent, person-centred care, nutrition, safeguarding, staffing and governance. The overall rating for the service was 'Inadequate' and this will remain. The service will remain in 'Special measures'. Services in special measures will be kept under review. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

Five safeguarding alerts for abuse had been up-held. Staff failed to recognise and report some allegations of abuse when needed.

Risk assessments were not always in place where needed. Care plans were not always personalised and did not always accurately reflect people's health needs and risks.

Quality assurance processes were not regularly carried out and had not highlighted the concerns we did during this inspection to keep people safe.

Is the service effective?

Inadequate

The service was not effective.

The service was failing to appropriately recognise and respond to people who were at risk of malnutrition and dehydration. Training in nutrition, hydration and pressure sores were not up to date.

Care plans for nutrition and hydration were inaccurate and did not reflect people's individual needs. Food and fluid balance records were incomplete and did not show if people were receiving adequate intake.

Staff did not understand the requirements of the Mental Capacity Act and the procedures for depriving a person of their liberty. There was also no evidence of 'Best interests' decision making.

Bellevue Healthcare Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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. Four adult social care inspectors completed the inspection on 5 September 2016 and three adult social care inspectors visited on 16 September 2016.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We reviewed feedback from the local authority commissioning team for the service, from the serious concerns protocol forum (which we have regularly attended) and from the CCG.

At the time of inspection there were 52 people using the service who were supported by 97 staff.

During the inspection we spoke with four people who used the service, one relative and a district nurse. We also spoke with the registered provider, manager, clinical leader, five nurses, 12 care staff and the cook.

We spent time with people in the communal areas and observed how staff interacted and supported people. We looked at nine care records, medicine administration records, weight monitoring records and pressure care records. We also reviewed staff rotas, staff recruitment records, safeguarding records and quality assurance records.

We looked around the service and went into some people's bedrooms and bathrooms (with their permission) and spent time in communal areas.

Inadequate

Is the service safe?

Our findings

One of the registered provider's directors, who is a retired GP and without a license to practice had been completing and signing 'Do not attempt cardio-pulmonary resuscitation (DNACPR), as senior consultant. This is a breach of the Medical Act 1983. We found that some people's DNACPR certificate stated 'general frailty' rather than a specific clinical condition, which does not following General Medical Council (GMC) code of practice.

This is a breach of regulation 12 (Safe care and treatment) and 17 (1) (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014. We found this to be a major risk and in line with our enforcement policy are taking action to address this matter, which we will report upon once completed.

On 5 September 2016 we identified that four people were grossly underweight and all had Body Mass Indicators (BMI) of below 18. This shows that people are at risk of being malnourished and developing a compromised immune function; respiratory disease; digestive diseases; cancer and osteoporosis. One person had a BMI of 12, which placed them at very high risk of developing life threatening health conditions. Despite referring people to dieticians in July 2016 the staff had not recognised that people continued to lose weight and that their BMI's were extremely low so had not got back in touch with the dieticians.

Where safeguarding alerts established that malnutrition or dehydration had occurred, there was no evidence to show that the service had taken action to reduce the risk of the incident this re-occurring. Also when people's nutritional supplements had not been received in a timely fashion the staff had not contacted the GP or dietician to request they were delivered. This had led to people not receiving the required supplements for over a month. In the interim these people continued to lose weight.
Food and fluid balance charts had not always been completed. Records showed that people consumed less fluid than were specified in their care plans. There was no evidence to suggest that people were offered snacks outside of meal times or that people at increased risk of malnutrition were offered nutritional supplements.

This is a breach of regulation 12 (Safe care and treatment) and 14 (Meeting nutritional needs) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

We found that staff were not identifying the development of pressure ulcers clearly. This meant care plans had not been produced to detail how these were being treated or the action they needed to take if the pressure ulcer changed or became infected. Staff had not been accurately identifying and recording when people had pressure ulcers. Referrals had not been carried out in a timely manner.

This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

During our comprehensive inspection of the service on 21 March, 5 and 18 April 2016, we identified that there were no quality assurance processes in place and the registered provider had not identified the concerns

which we had during inspection.

During this inspection, we found the registered provider visited the service every day, and observed them carrying out checks of the service and directing staff to take action where needed. We also saw the registered provider chatting with people who used the service; we could see that people knew them well. The registered provider was not recording any of these visits as part of quality assurance checks for the service. This meant we did not know what checks were being carried out or records of any actions taken to improve standards.

A small number of audits had been introduced at the service. Weekly medicine audits were carried out. However we found that these were checks of medicines stock rather than audits. Two audits for catering had been completed in July 2016, the first had been rated 'Red' and the second rated 'Amber.' Audits of care plans for six people had also been carried out but did not include people's names. This meant we could not track the person's care records to identify if any action had been taken to make the changes needed. Where audits had been carried out, they contained limited information. We could see that actions had been identified during the audits however no action plans had been completed and there was no evidence to suggest that these identified actions had been addressed. No audits had been carried out in relation to health and safety, safeguarding, accidents and incidents, record keeping and food and nutrition.

A recruitment exercise was taking place during our inspection. Two candidates were offered positions as care assistants on the day and were asked to start one week later. We were concerned about this because we could not been sure if two checked references and a disclosure and barring services check for each person could be obtained within this time frame. The manager and clinical lead told us that if this was the case, the candidate would commence their induction and would not be offered any shifts until these had been obtained. Staff files we looked at did not contain applicant interview notes or evidence that their identities were checked. As a result it was not always clear how the registered provider decided applicants were suitable to be employed.

On the day of inspection, a taxi arrived to take one person for a medical appointment. A staff member and member of the management team did not know about the appointment and questioned if the person required a member of staff with them.

This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

During our comprehensive inspection of the service on 21 March, 5 and 18 April 2016, we identified that risk assessments contained limited information and did not always match care plans and they were not regularly reviewed. We also found that some people did not have the risk assessments in place which they needed.
At this inspection, we found that risk assessments were not always in place for risks that had been identified for people. These included falls, and the use of call bells and lap belts. One person had a lap belt in place on their wheelchair because of a risk of falls, however a falls risk assessment had not been carried out. Another person had been assessed as at high risk of falls but a falls risk assessment had not been completed. For another person, their care plan referred to 'special measures taken to ensure that [person] is safe and free from harm' but did not describe what those measures were or how the person could be kept safe. Some people were not able to use call bells because of their health conditions. We found that no risk assessments had been carried out for these people. Care plans did not contain information about how staff would monitor people in their rooms if they could not call for assistance. People had no way of alerting staff if they needed assistance and needed to wait until a staff member came into their room to see them.

We found that some risk assessments were generic and not specific to the person's needs. Where risk assessments had been reviewed, staff had failed to identify any errors in the risk assessments. For example, a medication risk assessment in one person's care file had the incorrect name throughout. We could see this risk assessment had been recently reviewed but the errors had not been identified. Some risk assessments had not been reviewed in a timely manner. For example, a risk assessment dated 16 February 2015 which related to the health and safety of the building was on display at the service and had not been reviewed within the last year.
External support had been put in place to improve the management of medicines at the service. The service had started to make improvements to the management of medicines, however we found that further improvements were required. We looked at insulin management for people with unstable diabetes and found the information in the care records and medicine administration records (MAR) were difficult to follow. This was because staff did not clearly record how much was being given each time. This meant we were unsure if people were getting the insulin needed.

Topical medicine administration records (TMAR) were not accurate and did not reflect all of the prescribed topical creams people had in place. Some people had provided their own creams, which meant it was difficult to identify which were prescribed and which were not. This was because not all topical creams contained a prescription and some topical creams had been recorded on the TMAR when they had been provided by the person's relatives, and thus not prescribed by their GP.
One person had a care plan for personal care. This recorded three topical creams which needed to be applied twice per day and one prescribed shampoo which should be used when needed. A TMAR was only in place for one topical cream; this record stated that the topical cream should be used, 'As and when needed." This did not reflect the information contained in the care plan. This person had 12 bottles of prescribed shampoo in their bathroom; eight bottles of which were out of date. The nurse on duty took action to dispose of these.

Another person had five topical creams in their bathroom. Only one of these topical creams, Diprobase was recorded in the person's care plan as being prescribed by their GP. A TMAR was in place for Conatrane and Aveeno but not for Diprobase. When we checked these topical creams, we found Diprobase had not been opened. This meant we did not know if the person had refused to use the Diprobase and records did not show if staff had taken action to ensure a review of this person's topical creams had been carried out. The prescription labels on the Conatrane and Fucidin topical creams stated that they should be used, 'As and when needed.' This information was not contained within the person's care plans or TMARs. The manager and clinical lead told us that some topical creams had been provided by the person's relatives. We questioned whether a homely remedies protocol was needed. They told us they would look at this straight away.

Nutritional supplements for one person had not been written on the medical administration record (MAR). We could see they were prescribed on an 'As and when needed' basis however there were no records to show whether the person had needed them. Food balance charts were not up to date which meant we were unable to see whether the person had been the prescribed nutritional supplements. When we spoke with the nurse on duty and the registered provider they both told us the person had not needed them since being discharged from hospital because their nutritional intake had been good. The person also confirmed this to be the case. This meant the person's nutritional needs had not been accurately recorded.

At this inspection we found that all nurses on duty carried out a handover with all staff coming on duty. We saw records in place which supported staff to complete their handover. We saw one member of staff was late on duty; but the nurse on the unit provided a handover to them.

We looked at handover records dated 3 September 2016 and found two key points had been raised about two people. But when we looked at handover records dated 4 September 2016, care plans and care reviews we could not see what action had been taken to address the two key points raised.

There were gaps in records looked at during inspection. For example in handover records dated 3 September 2016, we could see that, "A little bit of redness applied cream" had been recorded for one person and, "Urine very bad smell" had been recorded for another person. There was no evidence of any action taken in either person's daily notes, care plans or handover records dated 4 September 2016.

This is a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

During our comprehensive inspection of the service on 21 March, 5 and 18 April 2016, we identified that care plans were not person-centred and lacked the detail needed to provide care and support to people safely and according to their wishes, needs and preferences. Care plans were not always reviewed within the timescales set by the registered provider and lacked detail. People had the same care plans in place regardless of whether they were needed. Some people did not have the care plans in place which were specific to their individual needs.

At this inspection we found new core care plans had been introduced. This meant that each person had the same care plans in place whether or not a specific need had been identified. For example, there were care plans in place for breathing and consciousness where people did not have any health needs. Care plans were difficult to follow at times, were not personalised and contained similar actions for each area of care for everyone looked at. Although care plans contained descriptions of what to do in relation to each care plan, they contained limited information about each person's individual needs. Some care plans were inaccurate and minimised people's needs. There were also gaps in care plan reviews during June and July 2016. Where people had short term conditions, such as infections no care plans had been put in place.

We spoke with staff on night duty and day duty about people's health conditions and individual needs. We gained mixed responses from staff. For example, one staff member could not tell us about two people's health condition and gave limited information about their individual needs. However when we spoke with another staff member we could see they knew the people they cared for well. For example, one member of staff we spoke with gave us a detailed description of how a person's support needs had changed in recent months.

This is a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Following our visit on the 5 September 2016 we wrote to the registered provider to make them aware of our serious concerns about people's welfare and asked them to take immediate action to ensure people's health was not compromised.

On 16 September we visited to check that they action the registered provider had said would be taken had occurred. We found that they had compiled a list of people's current weight and people who had wounds. They had contacted GPs and dieticians for all people who were found to have compromised weights and with wounds. Also they had ensured the cook was aware of people who were losing weight or had a low weight so the cook could provide these people fortified food. Additional supplies of fortified foods were provided throughout the day and the registered provider checked that people were eating. Although improved the records still did not fully evidence the actions staff were taking when providing care and

treatment for people.

We carried out a comprehensive inspection on 21 March, 5 and 18 April 2016 and found that safeguarding alerts had not been made by the service. We also found that staff training in safeguarding was not up to date and staff displayed very limited knowledge and understanding of what could constitute a safeguarding alert and the procedure which they needed to follow.

At this inspection we were aware that 14 safeguarding alerts had been raised with the local authority since 12 May 2016; seven had been raised by Bellevue Healthcare and seven by health and social care professionals. From these alerts, four alerts were substantiated for neglect and one substantiated for physical abuse. This meant that there was evidence to show that abuse had been taking place.

Staff gave us mixed feedback about working at the service. Some staff told us that they had seen changes taking place, however some staff did not feel all of these had been positive. Some night staff were concerned that they had not met the new manager who had been in post for three weeks. Staff on duty throughout the day told us there was a visible management presence at the service and felt able to approach them if they needed.

From speaking with staff, we could see they felt more positive about working at the service since our previous inspections during 2016. We asked a district nurse about the service and whether they had observed any positive changes. They told us, "Things have improved. I have no concerns but I only see residential people." Most people spoken to spoke positively about the staff who provided care and support to them. One person told us, "I'm getting looked after. I can do what I want. There is always staff here. It is OK."

Inadequate

Is the service effective?

Our findings

At our inspection on 12 May 2016 we found that when people lost weight staff were still failing to ensure referrals to dieticians were consistently made. During this inspection, we identified that the service was still failing to appropriately recognise and respond to people who were at risk of malnutrition and dehydration. Safeguarding alerts had been raised by health and social care professionals for people at risk of malnutrition and dehydration. The service had not raised alerts about these people. One safeguarding alert for neglect was up-held because the service had failed to act quickly to provide the care and support needed.

Systems were ineffective for ensuring people's nutritional needs were not compromised. For instance one person who used the service was identified as being at risk of malnutrition. We could see from care records that this person had significant weight loss and as a result a request had been made for a dietician to assess the person on 1 July 2016. Records showed that the dietician had visited the person on 7 July 2016 and instructed that the nutritional supplements that were being used needed to be replaced. When we looked at the person medication administration record we could see that the new nutritional supplements had not been given to the person until 2 September 2016. During this time the person had lost a further 1.7 kilograms in weight. We asked one of the team leaders on duty why they had been a delay with the supplement being given. We were told that the GP surgery had the prescription but had failed to send it to the pharmacy for processing so the registered provider had not received this until 1 September 2016.

Dieticians had identified that for people whose BMI was below 15 there was at risk of refeeding syndrome, which can be a very serious health condition. On the first visit we found that no care plan were in place where this may relevant but when we returned found that action had been taken to provide staff with the information about this condition.
During the inspection, we identified that another person had been losing weight. The person weighed 33.2 kilograms and had referred then to a dietician in July 2016 however staff had not proactively chased up nutritional supplements. These were not obtained until 1 September 2016. The person had continued to lose weight and weighed 31.7 kilograms at the time of inspection which meant they had a BMI of 14.

The registered provider told us that one person had been admitted into hospital in August 2016 as a result of health complications caused by dehydration and severely oedematous feet. We found that this person was at high risk of malnutrition and dehydration and had a BMI of 16 and weighed 53 kilograms. This information was not reflected in their care records.

We saw no evidence of people with compromised nutrition being offered snacks between meals and fortified meals. Food and fluid balance records did not routinely have snacks recorded and we identified gaps in the recording of food at mealtimes. Care plans for nutrition and hydration did not detail the action taken to monitor significant weight loss and any immediate steps that could be taken if the person continued to lose weight.

This is a breach of regulation 12 (Safe care and treatment), 14 (Meeting nutritional needs) and 17 (1) (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

People had care plans in place for their hydration which stated that 1.5 to 2 litres of fluids must be consumed each day. When we looked at people's fluid balance records, we could see that people were not meeting these totals as identified in their care plans. We looked at one person's fluid balance records between 24 and 27 August 2016 and 1 and 4 September 2016 and found their daily fluids totalled between 100 and 1000 millilitres of fluid for each day. We could see this did not meet their guidance contained within their care plan. There was no evidence to show what action staff had taken on each of these days.

Another person had been referred to a dietician, who advised that their fluid intake should be at least 1500mls per day. The person's fluid charts showed they were regularly taking less than this, and no action by staff was recorded. Staff did not always calculate the total fluids taken, which made it difficult to effectively monitor the person's intake. Their charts also showed they were offered but did not consume any fluids on 21 August 2016. There was no record of staff taking any action in response to this. A member of staff we spoke with about this said, "It has been picked up that. There are gaps in some of the paperwork."

Food balance records contained limited information and were sometimes incomplete. Records dated 24 and 25 August 2016 for one person had 'Coffee' recorded for their teatime meal and a record dated 26 August 2016 only had breakfast recorded. This meant that we did not know if this person had received adequate nutrition on these days.

We also saw they were also gaps in the information needed. For example, in one person's care plan there was no mention that there was a risk of choking which had been identified in other areas of the person's care records. A nutrition risk assessment also failed to identify this risk of choking.

Some people received their nutrition and hydration via Percutaneous endoscopic gastrostomy (PEG) feeding. This is way of introducing food and fluids into the body. We found that where this was the case, people were maintaining their weight. One person's care plan identified that the person must have 500 millilitres of water per day with their medicines via the PEG feed. There were no records in place to show if the person had received these additional fluids. There were no fluid balance charts in place, PEG feeding regime records did not include these additional 500 millilitres of fluid and nothing had been recorded in the MAR.

Another person had their PEG in situ but was being supported to eat solid food. The dietician recommended that a nutritional supplement should be given if a meal was not eaten to make sure the person was achieving appropriate nutrition. There were no records in place to show whether the person had been given any nutritional supplements. The manager and the person confirmed they had not needed any prior to our inspection however records did not reflect this.

This is a breach of regulation 12 (Safe care and treatment), 14 (Meeting nutritional needs) and 17 (1) (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

We found that training in nutrition had taken place, but only 23 nurses and care staff had completed it. Staff failed to recognise that one person's body mass index (BMI) was dangerously low. Only following the request of a visiting clinician was the person weighed and referred to a dietician. By that stage the person had lost 30% of his their body weight and weighed 44.9 kilograms. This matter was reviewed at safeguarding and neglect was substantiated. Following that finding we found that staff continued to fail to identify the continued risks to the person. We saw from their care records that they had continued to lose weight and at the time of the inspection was 39Kg. Yet staff had not seen this as a risk or that the person's BMI was now 12 so dangerously low and therefore had not re-contacted the dietician or proactively followed-up the delay in the supply of their new nutritional supplements.

We found that staff were not identifying the development of pressure ulcers clearly. Nurses and care staff had not received any training in this area. This meant care plans had not been produced to detail how these were being treated or the action they needed to take if the pressure ulcer changed or became infected. Staff had not been accurately identifying and recording when people had pressure ulcers. We identified that one person had seven pressure ulcers, which photographs contained in the care records showed were large. . The sizes of pressure issues recorded in care plans were not accurate and minimised the severity of the wounds. We found that staff had not taken action to inform tissue viability nurses in a timely manner. The service only took action to do this when the person had been referred to safeguarding and this had been recorded as an immediate action which the service needed to take.

This is a continued breach of regulation 12 (Safe care and treatment), 18 (Staffing) and 17 (1) (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

People's weights were recorded in a central location on each of the units at the service. The aim of this was to monitor people's weights more effectively. We identified that one person's weights had not been recorded centrally and they had been losing weight. Staff had recorded the person's MUST [nutritional risk assessment] at high risk. Malnutrition Universal Screening Tool (MUST) is a screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. The accompanying care plan stated that the person should be offered fortified snacks and staff should support the person to eat. During our inspection we observed this person's room and did not see this support offered by staff. From the available records, we could see that their weight had fluctuated from June 2016 between 52.9 to 54.7 kilograms. At the time of inspection they had a BMI of 18.3. For the person to be within the healthy BMI range, they would have needed to gain 10 kilograms however we found no evidence to show that staff had realised this or had taken action to promote this weight gain.

People were not weighed each month or week as identified in their care plans. For people who were required to be weighed each month, we found gaps of up to six weeks. One person who was required to be weighed each month, had been weighed more frequently. Weighed records dated 16 and 23 August 2016 identified a 3.3 kilogram weight loss. No further weights had been recorded since this time and there was no evidence of any action taken to identify whether this person was at risk of malnutrition. For another person, their weights were recorded in two different places and taken at inconsistent intervals despite being required weekly. For example, there was a four day gap between one weighing session and a two week gap between another. This made it difficult to effectively monitor the person's weight.

Where people were at risk of malnutrition, they were required to be weighed each week. This meant that staff could monitor these people more closely and take appropriate action. However we found that people were not always weighed within a week. Two people on the residential unit were required to have their weight recorded on a weekly basis due to high risk of malnutrition. We looked at records regarding the weekly weight of these people and could see that weights were not taken and recorded consistently on a weekly basis. For example, one person was recorded as being weighed on 20 August 2016 and was not weighted again until 30 August 2016. Another person was weighed on the 24 June 2016 and had not been weighed again until 17 July 2016. We could see that staff had recorded an 'incorrect weight' on the 24 July 2016 but no action had been taken to establish a correct weight. This person was not weighed again until 6 August 2016.

This is a continued breach of regulation 13 (Safeguarding users from abuse and improper treatment), 18 (Staffing) and 17 (1) (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

We could see that action had been taken to improve people's privacy and dignity, however staff were not consistent at making sure this was maintained. During inspection we observed people in bed with their doors open who were not appropriately covered. We also observed staff repositioning sheets with the bedroom door open and this led to the casual observer being able to see people in a state of undress or just in their underwear..

We spoke with one person in a communal lounge who was sat in a wheelchair and not in reach of a call bell. We took action to put the call bell within the person's reach. We had previously raised a safeguarding alert about this during an earlier inspection. There were some people on the nursing and residential unit who spent large parts of the day in bed who appeared to be isolated. We did not see staff proactively encouraging people to spend time out of bed. We noted that some of these people were reliant on staff for all interactions and during our observations we noted that these were limited. Where people had limited communication skills, care plans did not show how the person could communicate, such as specialist communication tools, noises or hand gestures.

This is a continued breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

When we looked in people's care records we found conflicting information where people could have capacity and lack capacity. We also found that training in the Mental Capacity Act (MCA) and deprivation of liberties safeguards (DoLS) was not up to date; at the time of inspection 29 staff had completed training. Care plans for emotional well-being stated that staff must, 'Act in the person's best interests and apply the principles of Section one of the Mental Capacity Act.' We could see this was incorrect because the Act stated that we must assume people have capacity. Where we feel that someone may not have capacity then a mental capacity assessment should be carried out. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves.

The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Some people were deemed to have capacity to refuse medical interventions and food but were also deemed to lack capacity to agree to stay at the service and thus DoLS authorisations were sought. Where people lacked capacity there was no evidence of any 'best interest' decisions making for any of their care needs such as administration of medication, provision of treatment. One person was recorded as lacking capacity to make good decisions regarding their own health and welfare however, no best interest decision were available in the care plan and there was no recordings of capacity assessments being completed. Records showed that another person had stated that they wanted to stay in bed throughout the day; however we noted that following a cerebrovascular accident the person was unable to speak and had been deemed to lack capacity.

Relatives were signing care plans and agreeing to treatment but there was no evidence in the care records where people lacked capacity to show whether their relative had Lasting Power of Attorney for care and welfare, yet they were being asked to agree to and sign to care plans.

We found that there were some restrictive practices in place without evidence of best interest decision making. For example, we found some people were in bed with minimal clothes on, such as an incontinence pad and protective underwear to keep the incontinence pad in place. In one care plan this was recorded as the person's choice but when we visited this person we found they could not communicate. Three people had lap belts in place on their wheelchairs to reduce the risk of falls. Two people had capacity and told us they were happy to use this. However, this had not been recorded in the person's care plan. One person did not have capacity and no best interest's decision making had been carried out. A risk assessment for bed rails for this person stated that their wishes had been taken into account.

This is a continued breach of regulation 11 (Need for consent) 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 5 Registration Regulations 2009 (Schedule 1) Registered manager condition The registered provider has failed to have a registered manager since 2014.

The enforcement action we took:

FPN

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider failed to ensure the nutritional and hydration needs of service users were met.

The enforcement action we took:

Sec 31 NoD

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 Governance systems were ineffective and failed to ensure that the director who was a retired GP and not licensed to practice signed DNACPR forms.

The enforcement action we took:

Sec 31 NoD