Malhotra Care Homes Limited

Belle Vue Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 30 July 2018 and was unannounced. A second day of inspection took place on 31 July 2018 which was announced.

Belle Vue Nursing Home 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 Nursing Home can accommodate 49 people in one adapted building across three floors. At the time of the inspection 39 people were resident, some of whom were living with a dementia.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe, effective, responsive and well-led to at least good. During this inspection we found improvements had been made.

The service had a registered manager who had been registered with the Commission since August 2013. 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.

It was evident that lessons had been learnt since the last inspection. Audits used as part of the quality assurance process had been reviewed to ensure they were robust enough to identify any necessary improvements.

Care records had been audited and re-written to ensure they reflected people's current needs. Plans were being developed for nurses to implement a peer reviewing system so they audited care records written by another nurse.

Improvements had been made to the management and investigation of any accidents and incidents. Safeguarding procedures were robust, well documented and investigated. Processes were used to identify any triggers and review for any learning. Improvements had been made to the admission procedure following a lessons learnt exercise.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice, however, we have made a recommendation about mental capacity assessments and best interest decisions. Specifically, in relation to locking people's bedroom doors.

Appropriate safety checks of premises and equipment was in place. The provider was reviewing fire safety

procedures, and work was underway to ensure compliance following a recent inspection by the fire service. All staff had been involved in fire drills and personal emergency evacuation plans were in place.

Staffing levels were sufficient to ensure people's needs were met. Staff told us they worked well together to ensure everyone's needs were met. Safe recruitment practises were followed.

Training was provided for staff which care staff were positive about. Nurses commented that they felt well trained however competency assessments were not always completed. It was explained that due to people's needs nurses were not using these skills however, should this change competency assessments would be organised. Everyone told us they felt well supported.

Medicines were managed safely and the registered manager had reviewed the medicine administration round to ensure everyone received their medicines in a timely and safe manner.

People were supported with their nutrition and hydration needs and given a recent heat wave hydration levels were being carefully managed. The home was involved in a study project with a local University in relation to assessing the impact of good hydration on the health and wellbeing of people living with a dementia.

If people's needs were such that specialist intervention was needed people were referred to healthcare professionals. For example, physiotherapists, speech and language therapy, dentists, options and specialist consultants.

A range of activities were provided and the activities coordinators worked to provide physical and mental stimulation for people. The sensory area had been moved into an empty bedroom which provided increased privacy for people.

Everyone we spoke with was complimentary of the care provided at the home. Care staff were respectful of people and treated people with dignity. We observed kind and compassionate relationships with people. One staff member was nominated for an unsung hero award at the providers forthcoming Gala event following observations of their compassionate approach.

Relatives told us they had no complaints but were aware of how to complain if they needed to. Lots of compliments had been received in relation to the care provided, particularly so in relation to end of life care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were administered safely and in a timely manner.

Staffing levels were sufficient to meet people's needs.

Safeguarding people from harm was understood and relevant risk assessments were in place.

Is the service effective?

Good

The service was effective.

We have made a recommendation about the recording of mental capacity assessments and best interest decisions.

People's nutritional needs were met and the dining experience was positive for people.

Staff told us they were well trained and well supported.

Is the service caring?

Good

The service was caring.

We observed caring and compassionate relationships between people and staff.

Relatives told us the care was good.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care records were up to date and reflected people's current needs. Staff told us they had improved since the last inspection.

Complaints were appropriately managed and many compliments had been received, particularly in relation to the

care and support provided when family members where supported at the end of their lives.

People were supported to engage in a range of activities.

Is the service well-led?

Good

The service was well-led.

There was clear evidence of improvements and lessons learnt following the last inspection.

Action plans were used effectively and were signed off once work was completed.

The quality assurance process had been reviewed and embedded to ensure continuous improvement.

Belle Vue Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 took place on 30 July 2018 and was unannounced. The provider did not know we would be visiting. A second day of inspection took place on 31 July 2018 which was announced.

The inspection team was made up of one adult social care inspector, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We contacted the local authority commissioning team, CCG and the safeguarding adult's team. We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spent time chatting with seven people living at the service and 12 relatives. As some people were unable to tell us about their experience of living at Belle Vue Nursing Home we used the Short Observations 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. We spoke with the registered manager, four care staff and two nurses. We also spoke with three ancillary staff, including domestic, laundry and cook, two activities coordinator's, the hairdresser, the head of care, the head of compliance and the compliance officer.

We pathway tracked four people, including their care and medicine records. We reviewed recruitment information for two staff and looked at supervision and training information. We looked at additional medicine records on the ground floor of the building and reviewed information relating to the management

of the service. A CQC evidence file had been compiled by the registered manager and compliance officer which we also reviewed. We looked around the building and spent time in the communal areas.

Good

Is the service safe?

Our findings

During the last inspection in July 2017 safe was rated requires improvement. We recommended the provider review the deployment of staff. We also identified concerns in relation to fire evacuation and the medicine administration round took a significant period of time to complete.

Following the inspection we received assurances that all concerns had been addressed and during this inspection we found improvements had been made. There was ongoing work in relation to the premises and fire safety.

Personal emergency evacuation plans (PEEPs) were in place and had been reviewed to ensure they reflected people's current needs. We discussed updating the PEEPs further once agreement had been reached on the specialist equipment to support staff to evacuate people down the stairs. Since the last inspection a process had been maintained to ensure all staff had attended fire drills.

Following a recent fire service visit some works were being carried out to fit new fire doors which would make compartments smaller. This would improve people's safety if there was ever a need to evacuate due to a fire. The fire emergency plan included the use of an evacuation chair to move people from upstairs to down in the event of a vertical evacuation. We noted there was no evacuation chair but instead an evacuation mat was to be used. We discussed this with the registered manager and compliance officer who explained there was an ongoing piece of work in relation to fire safety and evacuation procedures which would resolve these matters.

At the last inspection there were mixed views about staffing levels and this continued. The provider had however, reviewed the deployment of staff. One relative said, "I think they could do with a couple more staff, they all work very hard." Another said, "I think they could do with more but then it's the same everywhere." A nurse said, "We are not short staffed, we have the amount we need, it would be lovely to have more but we do have enough." Other relatives and staff told us there were enough staff. Individual dependency profiles were completed each month and this information was used to assess the required level of staffing. One staff member said, "There's enough staff, there tend to be two people in each lounge and we work together to support people, it works well." Our observations were that people were not waiting for support and staff attended to people's needs in a timely and supportive manner.

Safe recruitment procedures continued to be followed which included an application form and interview. If prospective staff were successful at this stage references and a Disclosure and Barring Service (DBS) were sought. The DBS service checks if individuals have a criminal conviction which supports providers in making safe recruitment decisions. DBS checks were renewed every three years. Nursing staff PIN checks were completed at the point of recruitment and on a monthly basis. Nurses are provided with PIN numbers from the Nursing and Midwifery Council (NMC) at the point of registration and checks are used to confirm there are no restrictions on their registrations.

Medicines continued to be managed safely. Following concerns at the last inspection the registered

manager had assessed the time it took to administer medicines and felt the time was appropriate and safe. We noted the medicine round happened in a timely manner. Nursing staff administered medicines for everyone who needed them. The care staff applied any creams. Medicine protocols were in place which had a photograph of the person and vital information in relation to their medicines, such as whether it was administered covertly, that is, without the persons knowledge, and whether they had any allergies. Medicine care plans detailed personalised information about how people liked to take their medicines, for example, [person] likes to take their medicines from a spoon with a glass of juice. Records of the outcome of medicine reviews were completed. A nurse said, "Any changes to medicines and we ask for it in writing from the GP practice."

Medicine administration records (MARs) were completed appropriately with no gaps. The nurse was knowledgeable about people's medicines and were able to explain processes to us clearly and with confidence.

Medicines audits had been regularly completed and had been effective in driving improvements. For example, it had been identified that any 'as required' medicines or refusals of medicines should be documented on the reverse of a MAR. This action had been followed and documentation was clearly recorded.

People we spoke with told us they felt safe. One person said, "Yes, I do I have my own flat here." Another person said, "Yes, I love it here I think it's beautiful." Another person said, "I do feel safe." Relatives also shared their thoughts that people were safe. One relative said, "Yes, I know she's safe and I can approach any of the staff."

People were safeguarded from the risk of harm. A safeguarding log was in place which documented the incidents that had occurred as well as any lessons that had been learnt to minimise the risk of a reoccurrence. For example, the admission policy had been amended to include a time frame for people to be registered with a GP. Care staff were knowledgeable about safeguarding people.

Risks to people were assessed and steps taken to reduce and manage them. Assessed risks included leaving the building, falls, moving and handling and bed rails. One relative said, "Staff support with mobility and getting around the home so they are safe." One person had a risk assessment for epilepsy which was being controlled through medicines. The person had not experienced any seizures however it may be of benefit to provide a description of the type of seizure the person experienced in the past so staff were able to identify it easily if it did occur.

Risk assessments had been signed on a monthly basis to say they had been reviewed. There was no content recorded so we were unable to see how it had been assessed that the risk assessment remained relevant. More detailed reviews were documented with care plans. We raised this with the management team who agreed to review the process.

Premises safety was well managed and the required certificates for gas and electrical safety were in place and in date. Equipment checks had also been completed as required. One staff member said, "It's about a safe environment, health and safety for the residents and us, any concerns I'd report to the nurse or the manager and document it."

The environment was clean and well decorated following a recent refurbishment of the ground floor and there were no malodours. Ancillary domestic staff explained they had schedules in place to maintain the cleanliness of the home. Staff were aware that the registered manager audited their work to ensure a high

standard was maintained. Cleaning products were safely stored in line with Control of Substances Hazardous to Health (COSHH) regulations and there was a good stock of personal protective equipment, such as gloves and aprons to ensure the risk of cross contamination and infection was minimised.

The kitchen was clean and well organised and food was prepared and stored following correct procedures. Staff had attended relevant training in food hygiene. In October 2017 the kitchen received a food hygiene inspection by the local authority was were given a rating of five which is 'very good.'

Good

Is the service effective?

Our findings

During the last inspection in July 2017 we rated effective requires improvement due to concerns around mental capacity assessments and best interest decisions.

Action had been taken by the provider and registered manager to make improvements. Further training in mental capacity and Deprivation of Liberty Safeguards (DoLS) had been provided. Mental capacity assessments and best interest decisions had been reviewed to ensure they were decision specific and copies of Lasting Powers of Attorneys (LPA) had been requested from family members. A LPA is a legal document that lets a person appoint one or more people, known as 'attorneys' to help them make decisions or to make decisions on their behalf if they lose the capacity to do so themselves. There are two types of LPA, health and welfare and property and financial affairs.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 improvements had been made. Best interest decisions were specific and had been developed for restrictions such as bed rails and wheelchair lap belts. The provider was continuing to complete 'agreements' for locking people's bedroom doors. We spoke to the registered manager and the compliance officer who said they had been considering whether a best interest decision should be documented as they were following the process. The head of compliance said, "It isn't really a restriction and the Mental Capacity Act is for life-changing decisions." The Mental Capacity Act 2005 Code of Practice states, 'The Act covers a wide range of decisions made, or actions taken, on behalf of people who may lack capacity to make specific decisions for themselves. These can be decisions about day-to-day matters ….. or decisions about major life-changing events.'

We recommend a further review of guidance relating to the mental capacity act and best interest decisions.

Staff were knowledgeable and told us, "It's about making best interest decisions for people if they can't make it themselves, we would follow the care plan." Care records contained information about any DoLS authorisations and copies of LPA documentation. Logs were used to monitor DoLS applications and authorisations. A LPA log was also used to monitor who had authorised LPA's and whether they were for finances and property or health and welfare.

People's needs and choices were assessed. A nurse said, "We do pre- assessments and have social worker information on dependency and diagnosis before people move in". The assessment information was then used to develop care plans and risk assessments which supported staff to provide effective care. A review was completed six weeks after people moved into the home to evaluate how they had settled in and ensure care and treatment was appropriate to their needs. Further reviews were completed annually.

Staff had attended training to ensure they were able to meet people's needs. A training matrix was used to ensure staff training was in date. This included dementia awareness, safeguarding and protection of adults, fire awareness, fluids and nutrition and moving and handling. Staff had also attended oral health care training provided by the NHS.

The training manager said, "The home is at 93% compliance with training. Dysphasia training is now live and we've done distressed signs and symptoms, everyone has done it who works here." Staff who were new to social care completed the care certificate, which provides a standard set of guidelines for everyone working in social care. A staff member said, "There's lots of training, it's face to face and online, we do moving and handling, first aid and fire which is face to face." A nurse said, "I'm doing a medicines diploma which is detailed and enlightening, it's a good learning experience. eLearning is completed and keeps us up to date so it's appropriate for revalidation. The care staff have good training." They added, "The only thing is no one comes to assess competency. We might do venepuncture (taking blood) or catheter training but we need our competency assessed."

The registered manager explained there was currently no one at the home whose needs required the nurses to have this competency. The head of compliance said, "We have someone available to assess competency if anyone has needs in this area." The registered manager explained that if someone had specific nursing needs the nursing staff would be trained and assessed as competent.

Staff told us they felt well supported. One staff member said, "We are supported by the manager." Supervision meetings were held regularly and were either on a one to one basis or in a group setting. This gave staff the opportunity to discuss any safeguarding concerns, health and safety issues, training and areas for development. Annual appraisals had been completed in March 2018.

Nutrition and hydration assessments were completed and staff were proactive in reporting any concerns to the nurse. If people had specific dietary requirements or difficulties swallowing assessments were completed by healthcare professionals. If people needed food to be pureed it was presented in an attractive way using specialist moulds to make the food look appetising. Meals were freshly made and people were shown plated meals so they could choose which they wanted. This meant people could not only see each option but could also smell it. One person said, "They ask me (what I want) when the food comes." We overheard a visiting professional say, "The food is fantastic!" People commented how lovely the food was and how much they enjoyed it.

Food and fluid charts were completed for everyone to ensure people had sufficient to eat and drink. In the recent heatwave this was particularly important to reduce the risk of dehydration. A nurse said, "We let the kitchen know about special diets, we have a form to let the kitchen now, things like vegetarians, Chinese preferences, gluten free, the kitchen know who has a special diet. We would also refer to the dietician or speech and language therapy (SALT)."

People had access to a range of healthcare professionals include dieticians, speech and language therapy, dentists and doctors. A recent change in opticians had led to benefits for people as staff had photographs of people's glasses and could identify when they needed to be worn. This helped staff encourage people to

wear the correct glasses and also aided identification if glasses were lost.

The team worked together to deliver effective care and support. A nurse said, "The team are good at raising awareness of any grazes or sore areas or if people aren't themselves. They know people well so they see the difference in people. I'm confident in the care team, you can rely on them." Care staff said, "The nurses are supportive and helpful" and "Our views are important and are respected."

Since the last inspection the refurbishment of the ground floor had been completed and plans were in place to refurbish the first and second floors. Mood boards with proposals for the décor was on display and one relative said, "The colours look lovely, I'm quite excited about it being done." Another relative said, "The environment is pleasant and the garden is accessible for people." Staff were aware of the plans and were hopeful that there would be minimal disruption to people when the work commenced.

People were able to access all the communal areas of the home with no restrictions. This meant people who lived on the first floor were able to go to the ground floor lounge/dining area or sit in the conservatory and look at the garden if they wanted to. We asked staff if this presented any concerns in terms of ensuring people were safe and appropriately supported. Staff said, "No not at all we know where people like to be and any paperwork, like food and fluid charts are just moved around for the staff to fill in. We all know everyone."

Good

Is the service caring?

Our findings

People and their relatives were complimentary about the care they received. One person said, "We all get along well here, we're very well looked after." Another person said, "The staff are lovely." They added, "They know what's important to me, I like to have a shower. When I was in hospital my [relative] brought me a box of chocolates from the staff, that was nice." Other people told us, "It's lovely here, the staff are good," "The staff are nice" and "I am well looked after here."

One relative said, "The care here is marvellous!" Other relatives made comments such as, "I think [family member] is very well cared for," "I think [family member] is as comfortable as they will ever be" and "[Family member] seems well looked after." One relative said, "All the staff know how to talk to [family member]. Their mood changes every day so they know how to take it each day at a time and change how they communicate with [family member]. The staff are great with me and friendly as well, I don't feel like I need to be here every day as I know they look after [family member] well." Others commented, "I'm happy with the care, it's very good," and, "Overall I feel it's one of the better ones. A good home. The care staff are good, very good."

We observed staff showing kindness, compassion and respect to people. Staff interacted positively with people and showed knowledge and understanding of people's individual needs and their life histories.

During an afternoon activity one person became particularly upset and we saw staff responded instantly. Staff approached them asking what the matter was and instantly sat on the floor so they were at eye level with the person. Verbal assurances were offered and physical comfort by way of hand holding was offered which the person openly accepted. Following a period of assurance and comfort the staff member was able to divert the person's attention back to the activity which they had they been enjoying. The staff member stayed sitting with the person holding their hand and joined in the activity with them. We later saw the staff member was supporting the person to their room. The engagement was so positive we later learnt the staff member had been shortlisted as a nominee in the 'Unsung Hero' category in the provider's Gala Awards Dinner in September 2018.

Other interactions were also kind and caring. When staff were supporting people with mobility needs one staff member led the transfer with a second staff member supporting. Reassurances were offered and staff explained what they were doing letting people know what was going to happen next. Staff also explained when the manoeuvre was over and made sure the person was comfortable, saying, "We are all done now is everything okay."

One person's relative was asked by a staff member how they were. The relative said, "That's just another example of how caring they are, they always ask how I am and how I am doing as they know I have been very upset." A staff member said, "It's important to know relatives are okay so we take care of them too." Another staff member said, "It's rewarding so see smiles on people's faces, it means we are doing something right. It would be nice to get a thank you form the manager now and again." We raised this and the registered manager said, "I do thank staff if they deserve it." We saw staff were thanked in team meetings.

If people had capacity, we saw they were involved in the development of their care records and in making decisions about the care they received. Collaborative care planning documents were completed to show who had been involved.

Relatives told us, "[Family member] cannot communicate very well, they can just say small words like yes and no so I discussed their likes and dislikes when they made it (care plans)." Other relatives commented, "Yes, I was involved, and I still am when they review it," and "I was involved in making that (care plans) and I do reviews with the nurses. At least once a year I think." Another relative said, "I didn't help with the initial development but I do come in for the reviews." Relatives also told us staff were communicative if their family member had had a fall or were unwell. One relative said, "They contact the family, sister has deputyship so they ring her."

Feedback was sought from people and their relatives using a survey. Results from the last survey in November 2017 had been collated and were generally positive with 100% of respondents feeling that people's privacy and dignity was respected and maintained. Some respondents had felt improvements were needed in relation to activities. In response photo albums had been developed to show engagement in various activities and a monthly newsletter was being produced to advertise forthcoming events as well as sharing photos of events that had happened in the past month. We were also told that a minibus was being provided which would enable staff to support people with day trips out. A further questionnaire had recently been sent to relatives and the registered manager was waiting for their return to collate the response.

Relatives had taken time to compliment the home and staff about the care their family members had received. There were many thank you cards offering appreciation. Some comments were, 'Thank you for all the excellent care', 'Thank you for all you have done,' 'Thanks to all the staff for your kind care, it means a lot knowing [family member] was well looked after.' One person's family had wrote, 'Words cannot describe how grateful we are for the care you gave [family member] during their time with you. You have all been wonderful and nothing was ever too much trouble for you.'

People's relatives told us the staff were conscious of the need to ensure people's privacy and dignity was respected. One relative said, "They keep [family member] clean and tidy, they need help with all personal care as they cannot manage it, but they keep a good eye on it." Another told us, "[Family member] does get really looked after here, the staff are always here for them."

During lunchtime we saw the chef who came to each dining area to serve the food and engage with people. Staff took the time to show people each meal choice that was available. This was particularly helpful for people living with a dementia who were able to respond and make a decision based on the options presented to them.

People could eat where they wanted to and were not assigned a place in a specific dining area. Lunch time was quiet and calm and people were offered a choice of drinks. Staff supported people appropriately and interacted positively with people, obtaining their consent before offering support. Staff checked people were enjoying their meal and encouraged them to eat a little more and to have plenty to drink.

Information on advocacy services was available for people and included information on IMCA services. IMCAs are independent mental capacity advocates whose role is to support and represent people in decision-making processes. None of the people currently supported had any specific communication or diversity needs.

Good

Is the service responsive?

Our findings

During the last inspection in July 2017 we rated responsive requires improvement. Care records had not been kept up to date and didn't always reflect people's current needs. The provider submitted an action plan detailing how improvements would be made.

During this inspection we found improvements had been made. The registered manager said all the care files had been audited and care records had been rewritten. Care plans included information about people's likes and dislikes as well as their life history which helped staff understand more about the people they were caring for.

One relative commented on the difference in their family member since they had moved in. They said, "[Family member] was aggressive and would not cooperate with staff in the last home. Within two weeks of coming here I've seen a good improvement."

A nurse said, "The nurses do the care plans, we have about 11 people each and we are responsible for their records. If there's a new admission we would initiate immediate care plans and do a capacity assessment and best interest decision for DoLS if needed." Care plans were in place for areas such as continence care, skin integrity, moving and handling, personal care and end of life care. Information was current and up to date and monthly evaluations had been completed which detailed how the person had presented that month and a short assessment of why the care plan was still relevant.

One person had a care plan in relation to positive risk taking. The person had capacity and had decided they were going to take a risk as they felt uncomfortable fastening a specific piece of equipment to keep them safe. It was documented that staff were to respect this person's choice but were to minimise the risk by being present whenever this equipment should be used.

Care staff were positive about the care provided to people. One staff member said, "We work across the whole home so we know every person and their care needs. We have handover which is detailed so you get to know everything. We would also check the care plans for any changes." Nursing staff also said, "We alternate which floors we work on so we are up to date with everyone's needs."

Social isolation care plans were used to record what activities people liked to join in with or whether they preferred to spend time alone or with quiet company. 'This is me' documents were completed which included people's family history and important events and times in their lives. This information was used so staff could get to know people, but it was also used by the activities coordinators to provide some activity or event that focused on people's interests or past experiences.

Two activities coordinators were employed. One person told us, "We had a summer fayre and I won lots of prizes. I like to play the dart game and I like to play dominoes." They added, "I don't know what's going on today. I like to have my hair done and [hairdresser] comes in and does it for me upstairs. They put curls in the way I like it." Another person said, "I like it when they do my nails."

Relatives were complimentary of the activities and commented, "They try to get [family member] involved with chair exercises as they have poor mobility," and, "There was an Elvis tribute band on a while ago and [family member] was actually singing and dancing. They used to love Elvis. It's the first time I've seen them get involved in an activity like that in years." Another relative said, "They do tai chi and chair exercises, there are quite a few activities and entertainments."

An activities coordinator said, "It's most important to get to know people and their likes and dislikes. We need to support people's physical health but also stimulate their mental health, music is amazing for people!" They went on to say, "Group activities are important but because of people's advanced dementia I like to do one to one with people. It's important records are kept of what's done with who so we can ensure everyone has regular activities."

We observed people enjoying a tai chi session which was a group event but also included very short periods of one to one time with the instructor. People joined in and looked like they were enjoying the activity and the exercise. We were also shown the sensory room, which had been moved into an empty bedroom since the last inspection. This afforded people some private space to relax and enjoy the sensory experience. People also enjoyed using the hairdresser and beauty area and of particular note was the hairdressing sink which allowed people to lean forwards to have their hair washed. The hairdresser said, "It's really good as some people find it quite painful and uncomfortable to lean backwards."

Information on how to complain was available within the home and any complaints received were logged and investigated. Outcomes of investigations were shared with complainants. A monthly complaint monitoring tool had been introduced which logged all complaints and whether they had been concluded to the complainant's satisfaction or whether they were ongoing. One relative said, "I've no complaints, I would know what to do if I did have, [registered manager] is here."

Relatives had taken time to compliment the staff for the way people had been supported at the end of their lives. One family had written, 'We would like to thank you all for all you have done for [family member] and making their last few weeks easier for them and treating them with kindness, we will think of you all with fondness.' Another family had written, 'One year on. My thoughts and feelings about how terrific you all were has not changed and so I send you a copy of the letter I sent you last year – the sentiments expressed then remain the same now.'

NHS palliative care guidance was used at Belle Vue Nursing Home to ensure good practice in supporting people at this difficult time. Palliative care meetings were to be held to discuss anyone's changing health needs and to ensure plans were in place to meet people's needs. The aims of the meeting were also to discuss any lessons learnt so improvements could be made to the care and support offered to people and their families.

At the time of the inspection no one was receiving end of life care. Care plans were in place which documented the need to provide appropriate nursing care such as anticipatory medicines, pressure relieving equipment and oral health care. There was a statement which read, 'ensure any spiritual beliefs are taken into account.' We discussed this with the registered manager and the compliance officer in relation to ensuring end of life care plans were personalised so people's final wishes could be met.

Good

Is the service well-led?

Our findings

During the last inspection in July 2017 we rated well-led requires improvement due to concerns found in relation to safe care and treatment, consent and good governance.

Following the inspection, we were sent an action plan which identified how the provider would work to be compliant in these areas. We found the registered manager, who had been in post at the last inspection, had worked hard to ensure improvements had been made.

There was a shared vision to promote person centred care and learn lessons to continuously improve the quality of the service offered. The registered manager had a visible presence in the home. Staff spoke highly of the support they received and the registered manager knew people well and understood their needs.

The registered manager said, "The action points from the last inspection have been attended to. We've done training and checks are in place. Capacity assessments and best interest decisions have improved and care planning. We have a daily checks file for the care staff to complete and it's all audited. Care records have all been audited." The compliance officer said, "We've worked on the action plan, everything is in an evidence file. We've worked on mental capacity assessments, have increased monitoring and checks are in place to monitor. The inspection is an opportunity to show improvements." They added, "We have been looking at the audits to ensure they are robust and if actions are completed. We are reflecting on the information to ensure it is all identified and linked to people's needs."

A nurse said, "I enjoy the job, it's a challenge but I like the staff and the manager. It's a friendly team, we all get on with it and knit together. It means there's a friendliness for the residents and we make things go as best we can for them."

Various systems were used to ensure the quality of the service was of a high standard. The compliance officer explained that since the last inspection the audits had been reviewed and amended to ensure they were effective at supporting the registered manager to identify areas for improvement.

Audits which had identified areas for improvement included action plans which specified who was responsible for the improvement and when the work should be completed by. We saw that actions had been signed off as being completed within the target time frame which had led to continuous improvement. The registered manager explained plans were being developed for nursing staff to be more involved in the quality assurance processes. This involved nurses reviewing and auditing other nurses care records to assess for compliance and quality. This would give a fresh set of eyes to read the information and ensure all requirements were being met.

Incident and accident audits were completed which included the actions taken to minimise reoccurrence or manage risk. This included information about staff being suspended whilst incidents where investigated to increased observations or contacting the persons doctor for a medical review. Nutritional audits were effective in identifying when people had lost weight and the action taken in response to this was logged. For

example, providing a fortified diet, updating care records or referring the person for GP or dietician involvement.

Provider audits were also completed which were used to assess the quality of the home and actions taken to learn and improve. Where actions were identified target dates were set for completion. Were improvements had been made this was also documented, for example, appraisals are more individual. It was also noted that the staff on duty at the time of the audit were friendly and approachable. Good positive interactions were observed.

Overall the systems and processes used to assess the quality of the service had been reviewed, embedded and used to good effect to improve the service. There was a much clearer focus and drive to evidence where lessons had been learnt and improvements made.

People told us they knew who the registered manager was and we saw them chatting with people and relatives. One person said, "I speak to him when he comes around." Another said, I've seen him briefly." Relatives said, "He's always available, I know if I am not happy I can approach him, I am happy to approach any member of staff." Another said, "We have a good relationship with him and all the staff." We were also told, "I had a chat with him this morning when I came in."

Relatives were invited to relative meetings with the registered manager, although the most recent one had been cancelled due to a lack of interest. Relatives did say communication was effective. One relative said, "Communication is good, we get plenty phone calls that keep us informed." Previous meetings evidenced that relatives were updated on the refurbishment plans, staffing levels and activities. Relatives were also given the opportunity to share any other business.

Staff meetings were held regularly and all staff were thanked for attending. They were provided with updates and information on specific areas of care, such as infection control and continence care, safeguarding, complaints and whistleblowing. There was also the opportunity for staff to raise any areas such as staffing levels and activities.

It was evident that lessons had been learnt since the last inspection and steps had been taken to improve the quality of the service to ensure sustainability. We were told by the compliance officer, "There is more demonstration and evidence of improvements, things are more accessible and more organised." Audits were more robust in identifying areas for improvement and checks were in place to ensure any action had been taken. The compliance officer said, "Systems are more robust now." Trend analysis was completed by the registered manager and the compliance team. To date no trends had been identified. Staff had been reminded in team meetings to alert the nurse to any marks or bruising so it could be reported to the registered manager who would investigate.

The registered manager explained they were part of a nutrition study with Northumbria University looking at ways to increase fluid intake of people living with a dementia. The aim was to see if this had a positive impact on peoples' health and wellbeing beyond meeting hydration needs, for example, a reduction in falls.