Amber Blossom Limited

BELVOIR HOUSE CARE HOME

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Belvoir House Care home is a residential care home providing personal care to 19 adults, some of who may be living with dementia, at the time of the inspection. The service can support up to 24 people.

People's experience of using this service and what we found
At times staff did not adhere to good practice guidelines on wearing personal protective equipment.

Risks to people while they received care had been identified. However, care was not always planned to keep people safe and care plans contained conflicting information on how to care for people safely. On occasion, staff deployment impacted on their ability to monitor people's safety.

Staff had been trained in how to keep people safe from abuse and the acting manager worked with other healthcare professionals to improve the safety of care provided.

The registered manager had been away from the home for a prolonged period. The acting manager ensured that the service continued to support people. However, audits to monitor the quality of care provided had not been completed.

Relatives were happy to raise concerns with the acting manager and were confident action would be taken to improve the quality of care provided.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 7 May 2020).

Why we inspected
The inspection was prompted in part due to concerns received about infection control and the registered manager being sick for a prolonged period due to COVID-19. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report. The provider did take action to resolve some of the concerns identified.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

BELVOIR HOUSE CARE HOME

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by two inspectors.

Service and service type
Belvoir House Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, the registered manager had been away from the home for a prolonged period and the home was being managed by an acting manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with the acting manager. We spent time observing care. We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke with three members of staff and four relatives about their experience of the care provided. We did this after the inspection to minimise our time in the home due to the risks associated with COVID-19.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

• People's needs were assessed and risks to people were identified. However, care plans contained conflicting or missing information about the care needed to keep people safe. For example, one person required their fluids to be thickened so they could drink safely, and this was not identified in their latest care plan. We saw another person's moving and handling care plan did not reflect their current needs. This meant that staff did not always have the information needed to care for people safely.

• Staff did not always ensure care was delivered in line with people's care plans. For example, one person's care plan noted they should be supervised when eating and as they were at risk of choking. Staff were aware of this and we saw the supported one person who started to cough when having a drink. However, at times there were no staff in the dining room to ensure this person remained safe. This put people at risk of harm while receiving care.

• People's risk assessments were reviewed monthly and changes in their needs identified. However, information on significant changes was not added to their care plan. This meant important information on how to care for people safely was not always easily accessible.

• Medicines were not always safely administered. For example, the medicines round was late and still being completed at 10:30 am. However, medicines were being recorded as administered at 8am on the medicine administration record. This inaccurate recording meant it was not always clear when the next dose should be given to avoid giving the person too much medicine.

• Medicines were not always administered to ensure people received the maximum benefit from them. For example, one person was prescribed pain relief medicine which needed to be dissolved in water. The person did not take all their medicine when given to them instead they took the single dose over a four-hour period. They had not referred the person back to their doctor to see if there was a more appropriate way to support this person with pain relief.

• Some medicines such as pain relief were prescribed to be taken as required. The protocols in place to support staff contained only basic information to ensure safe administration and did not provide person specific guidance on when they should be administered. Staff did not follow the good practice guidelines of recording why the medicine had been administered and if it had been effective for the person. This meant it would be harder for healthcare professionals to review if people needed different medicines to support their needs.

• Staff treated some medicine which had been prescribed as needing to be administered four times a day as an as required medicine. This meant that people were not getting their medicine in line with their doctors' prescription.

• Systems were not effective in ensuring that infection control standards were maintained in the home. For

example, we saw that staff were not always wearing their masks correctly. This increased the risk if staff passed on infections to people living in the home.
• The acting manager had not ensured that the equipment in the home supported good infection control practices. For example, there was no hand sanitising gel available when you moved between different areas of the home. In addition, some of the bins used for the disposal of clinical waste were not able to be opened using a foot pedal to reduce the need to touch the bin. These issues increased the risk of infection being spread in the home.
• There was a lack of understanding on issues which impacted on the ability to clean the home. For example, the visitors pod had stickers on to make it look more attractive. However, these stickers meant that it would be difficult to clean the pod effectively.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at an increased risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• Relatives told us there were enough staff to meet people's needs. One relative said, "Yes, yes, there seems to be a lot of staff." The acting manager had not formally assessed people's needs to ascertain the numbers of staff needed. However, they continually monitored the care provided and were able to increase staffing levels if people's care needs increased.
• Staff deployment did not always ensure staff were available to monitor people's safety when needed. For example, people at risk of choking were left unsupervised while eating. We identified this as a concern with the acting manager. They told us they would review staffing deployment to ensure people's safety was maintained.
• The provider had completed Disclosure and Barring Service (DBS) checks on people to ensure they were safe to work at the home. However, they had failed to ensure that accurate records were kept relating to gaining references for staff. Therefore, we could not be assured that the provider was following safe recruitment processes.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• Relatives told us that their family members felt safe at the home. One relative told us, "From what we know I think she feels quite relaxed and comfortable." Another relative said, "[Name] absolutely loves it, they say they are going to stop asking about going home as they like it there."
• There had been three recent safeguarding concerns about people in the home developing pressure sores. The acting manager had worked with the community nurses to identify areas where the care provided could be improved. Staff had received training in identifying pressure areas and staff deployment changed to ensure people identified as being at risk of developing pressure areas were reviewed by the senior staff daily. This action ensured that people were protected from harm.
• Staff had received training in how to keep people safe from harm. They were aware of the different type of abuse and were confident to raise concerns. They had access to contact information to enable them to raise concerns outside of the care home if needed.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• The registered manager had been away from the home for an extended period. The provider had appointed a senior carer as acting manager with support available from the registered manager of a sister home. However, the provider had not ensured that the acting manager had the skills, knowledge and experience needed to ensure the home continued to run safely.

• The provider had not ensured that the acting manager was able to complete all the responsibilities of managing the home. As the acting manager had stepped into the role during a COVID-19 outbreak they had not received a formal handover or introduction to the role. They were focused on ensuring the basic care to keep people safe was in place and ensuring that staff were competent in their role following concerns raised around pressure care. Therefore, audits to monitor the quality of care had not always been completed. For example, audits to monitor the infection control processes, quality of care plans and the safe management of medicines. The acting manager was aware of this concern and had identified all the audits needed.

• The provider had underestimated the amount of support that the acting manager would need as they lacked knowledge in areas needed to ensure care was provide in line with best practice guidance and regulations. They were not fully aware of which incidents needed notifying to the Commission for us to monitor the safety of the service. This meant that the provider had failed to ensure the safe management of the home.

• The provider had failed to provide a consistent set of policies for the home. Some had names of other homes on them and there was no system in place to ensure policies were reviewed on a regular basis to ensure they stayed up to date with guidance and legislation.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong: Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• Relatives told us that the acting manager was good at keeping them up to date with any concerns or changes in they care their family member received. In addition, relatives told us that they felt able to

approach the acting manager if they had any concerns.
• Some relatives we spoke with raised concerns that the visiting arrangements during the COVID-19 pandemic had not always been well communicated. They said, "I think they could make slight improvements. I think they could make more structured response to feedback for people like myself. I tend to think there is a bit over promising, such as a visit."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Relatives had not been surveyed recently about the quality of the care their family member received. However, they were all confident to raise any concerns with the acting manager. One relative described an issue they had, and the action taken to improve the care provided.
• Staff were complimentary about the acting manager and told us they felt well supported and that any concerns they raised were listened to. One staff member told us, "Yes - if I go to her, something is always done with what you are raising." Another member of staff said, "[Acting manager] has supported us really well. She has been there for us throughout it all. Without her we wouldn't have been supported."

Continuous learning and improving care; Working in partnership with others
• The acting manager had worked collaboratively with other healthcare professionals. When concerns were raised, they worked with the community nurses to learn and improve the care provided.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure risks were properly assessed and action to mitigate risks was not always effective. Medicines were not safely managed. Infection control processes were not dully in place to prevent infection spreading. Regulation 12 (1)(2)(a)(b)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems to assess, monitor and mitigate risks were effective. Regulation 17(1)(2)(a)(b)