

Countrywide Belmont Limited

Belmont 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

Belmont House Care Home is a care home providing personal and nursing care to up to 106 people aged 65 and over some of whom may be living with dementia. When we inspected 64 people lived in the service.

Belmont House Care Home can accommodate people across five separate units spread over three floors, each of which has separate adapted facilities. The unit on the top floor was not in use. One of the units provided residential care and three of the units in use provided nursing care.

People's experience of using this service and what we found

People were at risk of avoidable harm because the systems in place to protect them were not used effectively. This included lack of correct details in care plans for staff to follow and poor monitoring of people's health outcomes such as hydration, nutrition and pressure area care. Records in relation to people's health and well-being and advice from professionals were not a complete record of care and treatment provided. There was a lack of management oversight of accidents and incidents to ensure lessons were learnt to prevent a future reoccurrence.

The checks the provider made to understand quality and safety had highlighted most of the areas for improvement we identified. Action plans were in place, but effective action had not been taken to make sustained improvements.

People told us staff were often rushed and they had to wait for support. People also missed important support such as morning refreshments because staffing was disorganised. The provider re-arranged staffing immediately following our feedback. We made a recommendation for the provider to review how they seek and listen to feedback and make observations to ensure staffing deployment is effective and ensure people receive responsive person-centred support.

Belmont House Care Home staff team and people who use the service have lived through the stressful period as the pandemic has continued. They have also seen a turnover of staff and management. This has meant agency workers have supported the team. This experience has affected morale and people's view of the service. The provider is committed to providing on-going support to the team to impact positively on their morale and people's experience of using the service.

The introduction of the new manager has been a positive boost and staff told us they all focus their efforts daily on providing the best care possible to people. The provider has a plan to enable staff to do this moving forward. This included support for the team and the recruitment of permanent members of staff.

Medicines were well managed. The environment and equipment safety were managed well. Infection control ensured a clean environment and we signposted the provider to advice around how they can better support people to socially distance and manage staff arrival and breaks in the service to prevent

asymptomatic spread of the virus.

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 01 July 2019).

Why we inspected

We reviewed the information we held about the service and this highlighted risks we needed to review. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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 coronavirus and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Belmont House Care Home on our website at www.cqc.org.uk.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment of people and oversight of the service. Please see the action we have told the provider to take at the end of this report.

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our current re-inspection methodology. 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?

The service was not always safe.
Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.
Details are in our well-led findings below.

Requires Improvement ●

Belmont 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

On day one, two inspectors carried out the visit. On day two an inspector and medicines team member visited. Following the inspection an expert by experience telephoned people to understand their experience of using the service and two inspectors made telephone calls to staff. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Belmont 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 did not have a manager registered with the Care Quality Commission. This meant that nobody was legally responsible other than provider for how the service is run and for the quality and safety of the care provided.

A peripatetic manager had been deployed to manage the service by the provider and recruitment of a new registered manager was ongoing. The peripatetic manager will be referred to as 'manager' throughout this report.

Notice of inspection

This inspection was announced 24 hours prior to our visit to enable us to assess the risks in relation to COVID-19 prior to our site visit.

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 nine people who used the service and one relative about their experience of the care provided. We spoke with 17 members of staff including the nominated individual, manager, clinical lead, nurses, unit manager, senior care workers and care workers, housekeeping manager, group quality director, regional head of quality, regional director, quality and compliance inspector and specialist clinical nurse. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included seven people's care records and 11 medication records. We looked at two staff files in relation to recruitment and a further two regarding staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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 been rated 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; Learning lessons when things go wrong

- People were at risk of avoidable harm because care plans did not always contain up to date information about the care and treatment people required. For example; one person's diabetes care plan did not clearly explain the protocol nurses must follow.
- Where staff knew there was a risk to people's wellbeing, records were not always kept of progress and they did not formally discuss progress to understand if further action was required. For example; where people had lost weight, we were not able to determine what action had been taken.
- An assessment to understand if people were at risk of dehydration was not used. Staff were able to informally identify people were at risk, however complete records were not made to monitor progress.
- Where people had been involved in an accident or incident staff had recorded the details on the correct forms. However, the management section of the form had not been completed to understand patterns and trends and any lessons which could be learnt to prevent a reoccurrence.
- The provider had recognised some of the issues noted above as part of their quality and safety checks. However, action had not been taken to make sustained improvements.

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 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The building and equipment were managed safely. Staff took part in regular fire drills and evacuation practices to ensure they were able to respond in an emergency.

Staffing and recruitment; Systems and processes to safeguard people from the risk of abuse

- People and staff told us that the routine was rushed, and this impacted on care and support they received at times. For example, the morning personal care routine was not always finished in time to support people to have a morning drink on one of the units. One person told us, "I call, and no one comes. This is quite often. I try to make my way to the door to show physically that I need help, that seems to work better for a response."
- There was a risk the work routine and practices could lead to people receiving further poor care if action was not taken, which would be deemed organisational abuse. The provider and manager took this feedback seriously and instigated an immediate review of staffing levels and effective deployment in the service.
- The provider understood that the use of agency workers also impacted on people's experience and they had already taken action to recruit more permanent staff. Recruitment practices were safe.

- The provider used a tool to determine how many staff were required. The provider did not record when they made observations to understand staffing was safe or when they listened to feedback from people and staff.
- Staff had received training in safeguarding people from risk of abuse and knew how to raise concerns. Further bespoke training had been delivered to highlight the signs of organisational abuse and other forms of abuse. The provider had ensured there were opportunities for staff to raise concerns if they had any.

We recommend the provider review how their governance system takes into account and records feedback and observations of staffing to check deployment is effective and ensures people receive responsive person-centred care.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach in relation to supporting people to socially distance, use of staff cohorts and arrangements for staff arriving, changing and taking breaks in the service to prevent asymptomatic spread of the virus.

Using medicines safely

- Medicines were safely managed. One person told us, "The staff here always go the extra mile. I have lots of medication, they're always spot on."
- Where people used medicine patches it was not always clear on records if they had been rotated to different parts of the skin to prevent irritation.

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 been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created motivated staff to deliver person-centred care. Support from leaders to enable person centred care was required.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider made regular checks of the quality and safety of the service. These checks had highlighted many of the areas for improvement noted in this report such as, care plans being out of date, accident forms not completed, and weights not being managed. Action plans had been produced, however, action had not been taken to make sustained improvements and we found people were still at risk because of this.
- The provider needed to develop their approach to understanding safe and effective staffing to ensure people received safe and person-centred care.
- Some of the providers checks had not identified areas for improvement for example; where staff were not recording or monitoring people's health outcomes.

Systems were either not in place or were not operated robustly enough to effectively ensure safety and quality. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The team at Belmont House Care Home have experienced the intensity of working in a pandemic and suffered a significant outbreak. They have also seen a turnover in staff and management over recent months. The provider was working hard to ensure support and leadership was effective to develop and build the team and their moral moving forwards.
- The new manager's approach to leadership has been welcomed by the team and their person-centred approach. One member of staff told us, "The new manager came and introduced themselves and they seemed quite supportive."
- All of the staff we spoke with placed the people they cared for at the centre of their day. They worked to enable as much person-centred care as they were able. They understood the staffing pressures affected this at times and were keen to overcome this to improve people's experience living at the service.
- There was a definite culture of team working and all staff knew who their line manager was and that they could raise concerns and seek support from them. One member of staff told us, "I would say it is an open and honest culture. We can always have open and honest discussions. It is not a blame culture. I think we all know things can go wrong sometimes and we just try to learn from them."

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

- The provider and manager were transparent and open when things went wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The manager had started to engage with the staff and people they supported to understand their experience and to make a plan to involve them in any changes needed.
- The service had good relationships with the GP services, and they worked in partnership to ensure people received the healthcare they required.

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
Treatment of disease, disorder or injury	Risks to people's safety were not always assessed and monitored to ensure all that was reasonably practicable was done to mitigate risk and monitor well-being. Regulation 12 (1), (2), (a), (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes were not established and operated effectively to ensure safety and quality. An accurate and complete contemporaneous record was not kept in relation to each service users care and treatment. Feedback was not always sought and acted upon to evaluate and improve the service. Regulation 17 (1), (2), (a), (b), (c), (e), (f)