Belvidere Court Ltd

Belvidere Court Nursing Home

Inspection report

Woodcross Street
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West Midlands
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Website: www.belvidere.uk.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 9 and 17 February 2017. The first day was unannounced, and the second day was announced.

Belvidere Court Nursing Home is registered to provide accommodation and personal care and support to a maximum of 68 people. The home has 3 units, Kingfisher, Nightingale and Lark. The service provides care and support for older people living with dementia, and also younger people with varying mental health needs. There were 46 people living at the home on the day of our inspection. This was the first inspection since the new proprietors took over the service in April 2016.

A registered manager was in post and was present during our inspection. 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.

People had not been fully involved in developing and reviewing their care plans, and risk assessments, including how they wanted to receive their care and support. However, the registered manager had recognised this. They were implementing a new system for ensuring care plans were individual to each person. People were not always able to join in pastimes in the home, or supported to maintain their personal interests.

The registered manager had not submitted notifications about incidents within the service as they were required to do.

People were supported by staff who were provided with training to know how to support people. However, in some areas of the home, staff did not have time to sit and chat with people.

Staff felt supported by the management team. They were confident that they could approach the registered manager or the provider and be listened to. Safe recruitment practices were in place and staff had appropriate checks prior to starting work to ensure they were suitable to work with people who used the service.

People told us they felt safe living in the home. Staff were able to explain the actions they would take to keep people safe from harm. Staff told us that they were confident that any concerns about people would be addressed by the registered manager.

Staff sought people's consent to care and protected their rights under the Mental Capacity Act 2005 (MCA). Where people were being deprived of their liberty, the registered manager and provider was making appropriate applications. Staff supported people to have enough to eat and drink, and to have a balanced diet. People's day-to-day health needs were met, and staff supported them to access healthcare services.

People and their relatives knew how to complain about the service, and felt confident their concerns would be appropriately handled. The provider communicated with people and their relatives. Staff found the management team approachable

The registered manager had begun to implement new systems to assess, identify and improve the quality of service people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people's safety was not always identified on assessments.
People told us they were supported by sufficient numbers of staff. However, people could not always receive timely support. People told us that they felt safe. Staff understood how to recognise and report abuse. People received their medicines safely.

Is the service effective?

Good

The service was effective.

People were supported by well trained staff. Staff sought people's consent to care and support. People had the individualised support they needed to eat and drink. Staff supported people to access healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

People did receive caring, compassionate and dignified care and support. However, this was not consistent. Some staff did not understand how to interact positively with people who were expressing anxiety. Some staff did not always treat people as individuals or recognise their needs in a timely manner.

Is the service responsive?

Requires Improvement

The service was not always responsive

People did not always have personalised care plans or their preferences catered for. Not all people were supported to join in activities and pastimes. People's relatives knew how to complain to the provider, and felt confident about doing so.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Notifications that were required to be sent to CQC were not sent, or were not sent in the required timescales.
Quality audits within the service had not been consistently carried out. However, the registered manager had identified areas where improvements were needed. They had developed an action plan for improvement which detailed timescales for completion.
People, staff and relatives felt that the registered manager provided leadership and support to enable the service to improve.

Belvidere Court 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.

This inspection took place on 9 and 17 February 2017. The first day was unannounced, and the second day was announced.

The inspection team on the first day consisted of two inspectors, one specialist advisor and one expert by experience. A specialist advisor is a person with professional experience of supporting people who use this type of service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day there was one inspector.

As part of our inspection, we looked at the information we held about the service, including the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority and Healthwatch for their views about the service.

During our inspection, we spoke with 13 people who used the service, six relatives and three visiting healthcare professionals. We also talked to 14 members of staff, including the registered manager, the deputy manager, nurses, handyman, activities staff and care staff. We looked at ten people's care records, medicine records and MCA and DoLS-related records. We also looked at five staff files, training records, complaints, accidents and incidents records, menus and records associated with the provider's quality assurance systems

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to

help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We saw that risks to people's well-being were assessed when people's care was planned. These included risks to people's physical health and mental well-being. We saw that people who had been identified as at risk of falling had plans in place to reduce their risk of serious injury from falling. These plans helped people to retain their independence and we saw that staff understood and followed these plans. However, we saw that assessments for people who were living with acute mental health needs did not always contain sufficient information. They did not cover all the risks identified in the care plans and care records. In addition, they did not document past psychological difficulties which may reoccur. For example, one person had a history of self-harm. Their condition was such that there was a possibility that they may be in that situation again. Staff we spoke with were aware of this issue. However, they did not have guidance as to changes in the person's demeanour to suggest this may be a problem again. We saw that the risk assessments were reviewed, but changes to people's risks were not always captured in the assessments. The registered manager had already identified that more information was needed in risk assessments.

During our inspection we saw that there were enough staff to support people with care needs. People we spoke with felt that there were enough staff most time. However, we saw that, on the unit where younger people lived, staff did not have the opportunity to sit with people and have meaningful conversation with them. The provider had recently employed new staff and when there were shortfalls agency staff were employed. We asked staff for their views about staffing levels in the home. One said, "We have enough staff, if we need more they give them to us." Another staff member told us, "The management always take on board any concerns raised with staffing. Staffing is OK."

People told us they felt that staff protected them and helped them to be safe. One person said, "Yes I feel safe here, I think the staff are brilliant, if I need anything I just ask." Another person told us, "The staff are nice to me, they arranged a zimmer frame for me which helps me walk, which is good." A relative told us they were happy that their family member was supported well. They said, "I feel that my relative is safe here, the last place they were in they were always having falls, not here." Another relative commented, "[Person] has had two minor falls. They were assessed and now have a low mattress and a mat alarm on the floor. The staff rang me on both occasions to say they had a fall." We observed staff assisting people with mobility problems. We saw that people were assisted safely and appropriate moving and handling techniques were used.

Staff could tell us how they would recognise potential signs of abuse and how they would report these concerns. Staff were aware of the safeguarding process's in place in the home, and how to use them. For example, one staff member told us, "With any safeguarding concerns of abuse, including clinical issues I would report to the manager. I'm confident the management would take the appropriate action." Another staff member said, "I would inform the nurse, senior nurse or the home manager. If the situation was not addressed I would report it myself to safeguarding and the CQC." We discussed with the registered manager how they ensured any safeguarding concerns were dealt with correctly. They confirmed that they had improved the safeguarding processes in the home. This ensured all staff, including the management team, knew when and how they reported concerns.

We saw personal emergency evacuation plans (PEEPS) were in place for people who used the service. PEEPS provided staff with information about how they could ensure an individual's safe evacuation from the premises in the event of an emergency . As well as in care plans, the plans were in the Fire Evacuation file which would be used in the event of a fire. This meant that the information was easily accessible.

We reviewed five staff files which showed that the provider had taken steps to protect people from staff who may not be suitable to support them. Before staff were employed the provider carried out checks to determine if staff were of good character. They took up references from previous employers. They requested criminal records checks, through the Disclosure and Barring Service (DBS) as part of their recruitment process.

We looked at the administration and management of medicines. We saw that people were provided with their medicines when they needed them and in a safe manner. Arrangements for the ordering, storage and disposal of medicines followed national guidelines. The records identified each person's support needs and their preferred way to receive any medicines. One person we spoke with said staff supported them with their medicines. They told us, "Yes I get my tablets when needed, the nursing staff give them to me." We observed nursing staff safely administer medicines. This included an explanation to the service user what their medication was for. Nursing staff were knowledgeable about what medicines people were taking and what the possible side effects were. On the day of our inspection no people were supported to self-administer their medicines.

We saw that people had received painkillers as requested. Many people in the home were prescribed 'as required' medicines. These medicines were available for people when they needed them. We saw detailed 'as required' medicines protocols in some care plans. However, they were not seen for everyone. Because they were not kept with the daily medicines records, staff did not have immediate access to them. The registered manager confirmed that this had been recognised during their assessments of the service. We saw that further training had been organised with the pharmacist to address the issue.

Good

Is the service effective?

Our findings

The provider had systems in place to ensure that staff received training, achieved qualifications in care and were regularly supervised and supported to improve their practice. Staff were provided with the training that they needed to meet people's requirements and preferences effectively, including regular updates. Staff confirmed to us that they received high levels of training and support from the senior team. We saw that all staff were enrolled on an e-learning programme which contained all required training and many more topics related to staff roles. We saw that staff needed to complete modules and then undertook a test to confirm their understanding. All care staff were supported to attain the Care Certificate. This is a nationally recognised induction programme for new staff in the health and social care industry. One staff member told us that they had worked for the previous owners of the home. They said, "I repeated all the training when the new company took over and had additional training as well." Another staff member said, "I think the training I have had is enough for my needs. I have completed an NVQ level three here."

The registered manager had supported staff to develop new abilities. For example, staff whose first language was not English were enrolled on accredited learning programmes to enable them to improve their written, spoken and understanding of English. Also, staff who were not able to use computers well were supported to improve their IT skills. The staff had access to computers in the workplace to enable them to access their training programme when at work. One staff member said, "If I need training in a particular area, I feel I would be supported with any requests."

All staff were able to have time with the registered manager or deputy manager to discuss their progress. Staff told us, "The manager is very supportive. I have had one to one supervision where we discussed training needs and whether I had any issues. It is very helpful to me."

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. We checked whether the service was working within the principles of the MCA. Most staff had a good understanding of the MCA and what this meant in the ways they cared for people. Records confirmed that most staff had received this training. We also saw that further staff training was planned for the near future.

People were asked for their consent before staff supported them with their care needs. For example, before assisting people to mobilise or assisting them with personal care. The nursing team and care staff we spoke with demonstrated how they involved people as fully as possible in decisions about their care and support. Staff explained to us how they supported people to make their own decisions. One staff member said, "I always give people choices, even if they can't talk. I show them what clothes they have to let them pick." Another told us, "I help people make decisions by giving them choices about what they eat and drink."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS were in place where required for people and the appropriate referrals had been made to ensure people were not unlawfully deprived of their liberty. There were eight DoLS authorised and 17 awaiting authorisation at the time of our inspection. We saw that there was a good system in place to monitor progress of applications. We also saw that there was involvement of the person, their family, best interests assessors, psychiatric support teams and other healthcare professionals as required. Some people had restrictions in place within their DoLS authorisation. We looked at one person's support plan to see how the restrictions in place had been documented. We saw that the information in the plan did not give clear instruction for staff to follow to ensure the restriction was managed. However, the staff member in charge of the unit was able to explain what the restrictions were and the reason for them being in place. For example, one person was able to go out if accompanied by a staff member. The staff member confirmed that they worked with the person to support them to go out.

People were complimentary about the food provided. We saw people being offered hot and cold drinks periodically and people were also able to request hot drinks anytime. One person told us, "There is a good variety of food, lovely cups of tea, plenty enough to drink. We are able to have a hot breakfast if we want to." Another person said, "I enjoy the food, the cook is good." Relatives we spoke with also felt that the food and drink provided was of a good standard. One relative said, "I come in at lunch time, the food is excellent and varied. There is always two choices. [Person] is given plenty to drink throughout the day." Another relative said, "My relative had issues over not eating or drinking before they came in here but they are now a healthy weight."

All care plans we looked at indicated when people had a level of nutritional risk, and we saw people's weights were regularly recorded as part of assessing the level of risk. Where people had difficulties with eating or swallowing, they had been assessed by the Speech and Language Team (SaLT) to ensure their food and drink was safely prepared for them. We observed people being supported by kind and compassionate staff. The atmosphere was calm and relaxed. We saw that the support people received with their meals varied depending on their individual circumstances. Staff encouraged people to be independent. They also made sure those who required support were helped sensitively and respectfully to eat and drink enough and maintain a balanced diet.

People were supported to access healthcare services as required. One person told us, "I'm not on medication but if I need a doctor the home will get me one as soon as possible." We saw records which confirmed that people had been supported to access health screening services, opticians, dentists and chiropody. During the inspection, we spoke to two health care professionals who were visiting the home. One health professional told us, "The information that has been given about my client is good, care is good here and I can't fault the place." Another health care professional stated, "Yes, they are much better in responding to resident's conditions since the new provider has taken over." The GP visiting the home told us, "Staff are appropriately trained and deal with any requests and instructions competently."

Requires Improvement

Is the service caring?

Our findings

We saw that people benefitted from positive engagements where staff demonstrated empathy, understanding and warmth towards them. For example, in one of the units a member of staff was attentive to all those present in the lounge including one person who was becoming anxious. The member of staff sat with them, asked what was wrong. They explained things clearly to the person and provided reassurance in a meaningful way, which put the person at ease. However, on the same unit we saw other staff did not understand how to interact positively with people who were expressing anxiety. For instance, we saw one person for whom English was not their first language. This person became very agitated after lunch. They were speaking loudly then shouting out in their birth language whilst sat in the lounge. Staff were slow to offer support to this person, who continued shouting. We saw that other people in the room were becoming agitated. At one stage a staff member sat down next to this person to complete records but did not engage with them. We asked one staff member if this was this person's normal demeanour. They responded, "Yes, [person] is always like that after lunch – it is who [person] is." Although there were staff who spoke the person's first language, they still spoke to them in English.

We spoke with one person who was sat in front of the TV. They told us they couldn't see the film, despite wearing very thick lensed spectacles. When we asked staff about the person's vision, we were told the person preferred those glasses even though they belonged to someone else. We asked the staff member to get the person's own glasses. After some time the person's own glasses were found and handed to them. They then said they could see the film. Staff knew that the person was wearing another person's glasses, but took no action to find their own glasses until requested by the inspector. This did not show respect for the person's belongings, or understanding of their visual needs.

We spoke with two people who were living with long term, complex mental health needs. They were not able to recall being involved in deciding what care and support they wanted. Psychological care plans were not individual to each person. The plans labelled the person's condition, rather than the individual support needs of the person to manage their condition.There was no evidence to show that people had been involved in the reviews and evaluations of their care plans. We asked one staff member how they knew what people wanted. They said, "We do our best to try and work with the resident or their family members." However, the plans did not reflect this.

People who were able to provide an opinion felt that the staff team were caring. One person said, "I love it here, it's lovely. Very nice staff, I don't need anything" Another person told us, "The home is great, the girls are wonderful. I have no complaints what so ever, really pleased with this place." We observed people who were not able to express an opinion and saw that they were treated with kindness. Their body language, including smiles and touch towards the staff showed us that they were at ease with staff.

Family members were happy with the care provided for their loved ones. One relative felt that the staff looked after them as well as their family member. They told us, "They definitely consult and I am kept informed. They rang me one Sunday as [person] had a high temperature. I went to hospital with them. When we came back late from the hospital, they gave me a hot drink and called a taxi for me to go home. They had

my interests at heart as well." One relative said, "My family member can be aggressive, but they deal with them wonderfully. There isn't one member of staff that is not one hundred percent committed." We were also told, "All the family think that our relatives level of care is good. Staff are friendly to all of us when we come in to see our relative." Another family member commented, "My relative is getting excellent care, the staff can't do enough for them. They meet my needs and my relative's needs. The staff reassure you, if my relative needs more medication they keep me in the loop." Another said, "I have worked in care homes and I know what is good and bad. This place is good There is definitely a good caring attitude amongst staff."

We observed staff treating people with dignity and respect and being discreet in relation to personal care needs. For example, one resident was visited by a health care professional, however the resident did not wish to move from the lounge area, therefore staff allocated a dignity screen to enable the health professional continue taking basic observations with dignity and respect. One staff member said, "With personal care, I always ensure they are covered up, doors closed. I always respect their wishes and leave the room to give them privacy. This how I would want to be treated."

Information about advocacy services for people was available. The registered manager had also provided an easy-read document called "Your right to have an advocate." This leaflet explained simply about advocacy services for people.

Requires Improvement

Is the service responsive?

Our findings

People had not been fully involved in developing and reviewing their care plans, including how they wanted to receive their care and support. Care plans were generic in format and did not always provide guidance to staff as to how they could support people well. For example, one person's care plans referred to changes in their behaviour, including reduced ability to make decisions, when they had 'an episode.' There was no information as to what the episode was, how often it occurred or how it affected the person. We asked one staff member if they knew what the 'episode' was. They were unsure but said, "I think it is when [person] is feeling down. They then don't talk." We met this person on the day, but they were not able to discuss the support provided at the time.

The registered manager told us that the process of reviewing and updating people's care plans had fallen behind due to previous staff shortages. Although the staffing issues were now resolved, the staff team told us that they lacked the time required to update and evaluate care plans. One staff member confirmed, "We have problems with documentation, which we are addressing." Another staff member said, "I would like more training and support with care plans. I keep on being told I know the residents, but I would like more support." We asked the registered manager how the staff team were supported to complete the care plan reviews. They acknowledged that this was an issue. They confirmed that they were looking at providing extra hours to staff to enable them to complete the plans.

We saw that people, who were independent, were encouraged to go out into the community as they wished. Two people told us that they liked to go out to the pub and get a newspaper everyday. However, one person thought that, if there was more staff, then people who needed accompanying would be able to go out more. Some people were able to tell us about their opportunities to enjoy their preferred pastimes. For example, one person said, "I enjoy the canal trips and crosswords, like reading books and watching the TV." We enjoyed chatting to another person about their favourite radio stations and musical likes and dislikes. However, during the inspection we saw areas of the home where support to enjoy pastimes was lacking. We found there was a lack of structure to ensure all people had the chance to join in with activities. We saw the activities schedule was displayed on the notice board in the entrance to each floor of the home. There were two activities listed for every day of the week, although it wasn't clear where in the building activities were taking place. The activity coordinator told us they made staff aware on each floor where activities were taking place and relied on them assisting people to the relevant location. On one unit, we saw that a DVD film was being played for people. The film was on a loop setting and was played three times in a row before being changed. One staff member told us, "During the week, there isn't a lot of activities for people, even though we have an activity coordinator." One relative said, "I have never seen activities."

People told us that they knew who to speak to if they had a concern. On the unit where younger people lived, we saw that people were comfortable talking with the staff team who supported them. One person said, "I will tell [staff member's name] if I have any complaints. They will sort it out for me." Another person told us, "The management are very accommodating. They often ask me whether I'm happy with things here." No relatives had made any complaints. All relatives we spoke with said that they were confident that if they had any concerns they could approach staff or management. The felt they would take their concerns

seriously. One relative said, "I have no complaints at all, always made to feel welcome and offered a drink of each visit." Another relative told us, "I have no concerns about how things are managed and I can be very open and honest with the manager, who has an open door policy."

The provider's complaints procedure was seen on the noticeboard in the reception area. In addition, the provider had a large print complaints procedure for people with visual difficulties.

Requires Improvement

Is the service well-led?

Our findings

We found the registered provider had not submitted notifications to the CQC as required under the terms of their registration. Incidents concerning allegations of abuse, serious injury and matters involving the police had had taken place over the preceding 10 months, but not reported to the CQC. The registered manager told us they were not aware that they needed to notify CQC as they assumed that the safeguarding team had done so. In addition, there were delays in sending the required notifications if a person had died, and if a DoLS was authorised.

This was a breach of regulation 16(1) and 18(2) of the Care Quality Commission (Registration) Regulations 2009.

Quality audits within the service had not been consistently carried out. The registered manager told us that this was because of the staffing difficulties they had over the last six months. However, the registered manager had begun to address this in the home.

The registered manager had sought the views of the people and their relatives about the service provided. However, the information was sparse and had not been used to improve the service. This had been identified by the registered manager and was included in their future plans.

The provider had purchased the home in April 2016. The registered manager acknowledged that they had faced complex issues when they took over the service which had a negative impact on the care and support provided. During this time, they identified many areas for improvement. This included the transfer of staff from the previous provider who did not have the required training in place. They had worked to bring the standard of staff training up to the required level. The registered manager told us, "We started at the beginning and re-trained the staff team. Even if they had the relevant certificates, they did the training again. This enabled us to know exactly what training staff had." This was confirmed by staff members. Staff told us that they appreciated the support provided by the new owners and registered manager. They told us that they felt more motivated and that they knew what was expected of them within their role. Staff reported that the new management changes had delivered some good results within the home. They had introduced new ideas. For example, they had improved staff communication with better handover information. Staff felt that this helped to ensure communication was effective in relation to resident's well-being and support.

Staff told us they felt there was an open and transparent culture amongst the staff team. They confirmed that it was a good service to work for. One staff member said, "We always try and look for the positives. Things have been difficult at times but we work together as a team and now we have the support we need to go forward." Another staff member commented, "I do think the manager values our opinions. We are a passionate team and I think you must have passion for this job. We work together well though and we're sure the new manager will make the difference." A third staff member said. "The manager is supportive towards me. I feel that I am able to approach the manager about anything." Other comments included, "I have lots of support, it is a good place to work." "The manager very good, and will listen to me." And, "There has been lots of changes with new provider for the better."

The provider had a policy with regard to the management of unsatisfactory staff practice. This included one to one support meetings, supervisions and disciplinary hearings where required. Staff were encouraged to question practice and understood how to whistleblow if they felt they needed to. Whistleblowing is when a staff member reports suspected wrongdoing at work. Staff told us they were confident that if they reported any concerns about abuse or the conduct of their colleagues the registered manager would listen and take action.

Records of accidents and incidents were analysed monthly to show when and where incidents had occurred. We saw this had been used to identify any trends which may indicate further action was required. For example, we saw that one person had been found on the floor in their bedroom on a number of occasions. The concerns had been discussed with the relevant healthcare professionals and family. The registered manager had taken steps to reduce the risk of injury by the use of laser operated crash mats by the person's bed. The person's relative told us that they had been involved in the decisions taken.

The registered manager acknowledged the difficulties they found when they took over the home in April 2016. They had employed an experienced nurse as deputy manager to support them in improving the lives of people living at the home. We saw that they had developed a good professional relationship which was positive for the future of the service. The deputy manager had experience of caring for the needs of the people living at the home and had identified areas for improvement. They had developed an action plan for the on-going improvement of the service provided. The registered manager shared with us their action plan. The priorities identified were around recruitment, staff support, updating care plans and administration systems, quality audits and further development of the environment.