Vitality Care Homes Ltd

Belgrave Court Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Belgrave Court Residential Care Home is a residential care home providing accommodation and personal care to up to 30 people, some of whom may be living with dementia. At the time of our inspection there were 23 people using the service.

People's experience of using this service and what we found
People did not receive a safe, well led service. Governance systems in place to ensure the safety of people continued to fail to identify concerns.

Auditing systems continued to be ineffective and paperwork continued to be inaccurate or available. Lessons had not always been learned because the same issues remained from the previous inspections and outcomes for people were not always positive.

People were not always safe. People were at risk of harm as the provider had not identified, assessed or mitigated risks. This included risks related to people's health and care needs, as well as environmental risks.

Medicines management continued to be unsafe which put people at risk of harm. We still could not be assured people received their medicines as directed. People who received time specific medicines did not receive these in line with the prescriber's instructions. Stock checks were not always consistently completed or correct.

Recruitment and staffing remained a concern. Appropriate robust checks were not always completed prior to new staff commencing employment. Staffing levels were not sufficient to meet the needs of the people in the service. People, relatives and staff all commented about the need for more staff at the service.

At our last inspection, we found concerns related to the management of medicines, welfare and environmental risks, infection control practices and limited and ineffective oversight of the service.
At this inspection, there continued to be a lack of effective oversight. The provider had failed to learn lessons from the previous inspection and had failed to implement measures to improve the quality of the service.

People were supported to have maximum choice and control of their lives and staff supported did them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

There had been some improvements made to the environment, bedrooms had been refurbished. The provider had an action plan in place to show when the remaining rooms would be completed in line with the refurbishment plan for the service.

A new manager has started at the service and was hopeful to improve the shortfalls identified. Following the inspection, they informed us that they had increased staffing levels at busier times and were working

alongside staff to improve their practice.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 7 March 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. The overall rating for the service has remained inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

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.

You can see what action we have asked the provider to take at the end of this full report.

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

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 and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing, recruitment and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore remaining in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Belgrave Court Residential 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 Health and Social Care Act 2008.

Inspection team
The inspection was completed by one 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.

Service and service type
Belgrave Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Belgrave Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of the inspection the manager was not registered with CQC. The manager informed us they intended to submit their application to be registered.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service and five relatives about their experience of the care provided. We spoke with eight members of staff including the nominated individual, the manager, administrator, senior care workers and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider.
We carried out a visual inspection of the home to assess the living environment and observed interactions between staff and people who lived at the home.

We reviewed a range of records. This included four people's care records, and multiple medication records. 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. The manager sent us further information which included two staff files in relation to recruitment and quality assurance documents.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At the last inspection effective systems were not in place for the management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider continues to be in breach of Regulation 12.

- Medicine were not managed safely.
- The provider had implemented an electronic medicine monitoring system. On reviewing this system, we identified the same discrepancies with the administration of time sensitive medicines as at the last inspection.
- Staff who had not received medicines training were preparing medicines for people prior to administration.
- Protocols for 'as and when required' medicines did not contain sufficient details to inform staff how and when these medicines should be given.
- Stock checks for medicines were not always consistently completed or correct. We could not therefore be assured that people had received their medicines as directed.

There was a failure to ensure the proper and safe management of medicines. This is a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider addressed the concerns with time specific medicines.
- Following the inspection, the provider took action to ensure all medicines including food supplements were prepared and administered by trained staff.
- Following the inspection, the provider told us they were planning to increase checks to ensure medicines were safely managed.

Assessing risk, safety monitoring and management

At the last inspection effective systems were not in place to assure us risks were identified, assessed and managed. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider continues to be in breach of Regulation 12.

● People were exposed to the risk of harm in the event of an emergency, as risk was not appropriately managed. Whilst the provider had addressed the concerns from the last inspection regarding personal emergency evacuation plans we identified people who were at risk of harm due to their surroundings and the provider had not considered the potential impact this could have.
● Accident and incident forms continued to be poorly completed. Staff were not always aware of injuries caused and follow up care was not in place to ensure effective care was received by people.
● Care plans were updated following an accident, however very little information was recorded to inform staff of any action or support the person required when injuries were sustained.

The provider had failed to ensure that people were protected from the risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider responded immediately during the inspection to ensure peoples surroundings were suitable and to minimise the risk in an emergency situation.
● The provider told us following the inspection that they had introduced a new handover process to ensure accurate information following an accident is shared with staff.

Staffing and recruitment

At the last inspection the provider had not ensured recruitment procedures were established and operated effectively, in line with their own policy, to ensure only suitable staff were employed. This was a breach of Regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider continues to be in breach of Regulation 19.

● Recruitment was not robust. The registered provider had failed to follow its own recruitment procedure. Appropriate checks were not always completed to ensure people were of a suitable character to work with vulnerable adults. For example, staff did not record their full employment history and there was no evidence of this being explored by the provider.

The provider had not ensured recruitment procedures were established and operated effectively. This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People, staff and relatives did not feel there was enough staff. Comments included "We need more staff, there are so many people who require two staff to support them others are left waiting" and "They [the service] are still struggling with staffing levels."
● The provider used a dependency tool to determine staffing levels. However, rotas showed that there were times where there weren't appropriately trained staff on duty to provide medicines to people who required them.
● There was not always enough staff to meet people's needs in a timely manner. For example, during an afternoon care staff were taken away from supporting people to prepare the evening meal which then left

only two staff to support 23 people, nine of which required two staff to assist them.
● At the last inspection were not assured that the provider was adequately training staff. At this inspection we identified further concerns in relation to training. We could not be assured all staff had been provided with the appropriate training as staff induction and training records were not always up to date.

The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure people's care and treatment needs were met. This was a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the manager informed us that they had increased staffing during busier times of the day.

Learning lessons when things go wrong
● The provider had not learnt lessons from areas identified at the last inspection. Some of the same areas of concern were found at this inspection.

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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Systems and processes to safeguard people from the risk of abuse

At the last inspection the provider failed to ensure that people were protected from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made and the provider was no longer in breach of this regulation.

● Systems and processes were in place to ensure that people were protected from abuse. Referrals to the local safeguarding team were completed in a timely manner.
● Staff received safeguarding training and were aware of the action to take to ensure people were safeguarded from abuse.
● We received mixed feedback from people about the service. One person told us "It is ok here, it's not the best but I can do what I want." Another person told us "I am not happy but that is because I'm stuck in this room."

Preventing and controlling infection
At the last inspection effective systems were not in place to assure us infection risks were managed. This was

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

Enough improvement had been made and the provider was no longer in breach of regulation 12.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● 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 promoting safety through the layout and hygiene practices of the premises.
● 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.

Visiting in care homes
● The provider was facilitating visits in line with guidance. However, each relative we spoke with described inconsistencies regarding the required visiting procedure. We fed this back to the provider, who told us that visiting guidelines were explained to relatives when they phoned the home to book an appointment to visit their family member.

Inadequate

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 our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At the last inspection systems were not robust enough to demonstrate effective oversight of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulate Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider continued in breach of Regulation 17.

● Governance of the service continued to be inconsistent. The provider continued to fail to understand their role and responsibilities. This was the fourth consecutive inspection where concerns were found in relation to record keeping and oversight of quality at the service.
● The provider did not follow the principles of good quality assurance systems or evidence how improvements were to be achieved.
● Audits to monitor the quality of the service did not always contain the correct information. They did not always identify actions taken or learn lessons to improve the service.
● The provider had an improvement plan in place for the service. However, this was not robust and did not fully address all issues that were found at the last inspection. There was no improvement plan for all significant concerns identified at the previous inspection.
● The provider's medicines audit had not been effective in identifying the concerns we found in relation to medicines not being administered as prescribed.
● The protocol for staff working on a night who were not trained to administer medicines was not appropriate to meet people's needs and wellbeing.
● There had been some improvements to the information recorded in care plans and the reviews of these records. However, this had not been firmly embedded. At times there was not enough information recorded following accidents and some care plans contained contradictory information about people's needs.

Quality assurance systems were not effective or adequate to identify where areas of improvement were required and to ensure improvements were embedded at the service. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

● The provider had failed to inform CQC of safeguarding concerns raised with the local authority.

The provider failed to notify CQC of safeguarding concerns. This will be dealt with outside of the inspection

● A new manager had been recruited and had been at the service two weeks prior to the inspection. The provider was confident that improvements could be achieved with the new management.
●The manager was aware of their responsibilities in relation to the duty of candour and ensured relatives were kept informed about significant events

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Some people were not happy within the service. The provider addressed this during the inspection and made changes to ensure people's wellbeing was considered.
● The new manager was working with staff and relatives to promote a more person-centred approach at the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The provider informed us they had attempted to promote and encourage staff opinion by providing an anonymous comments box for staff to provide feedback anonymously and had offered staff the opportunity to complete satisfaction surveys so that improvements could be considered.
● We received mixed feedback from relatives. Some relative could see improvements with communication and cleanliness of the service. Other relatives said they felt more communication was needed and the service was not always clean.
● The provider ensured government guidelines for working safely in care homes during the COVID-19 pandemic was adhered to.
● The provider continued to work with stakeholders to make improvements at the service.
● The provider had sought an external agency to obtain feedback.