Almondsbury Care Limited

Belmont House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Belmont House Nursing Home is a residential care home providing personal and nursing care. The service can support up to 40 people. There were 29 people living in the service at this inspection.

People's experience of using this service and what we found
People were at risk of harm because the systems in place to ensure they received safe and appropriate care were not effective. Care plans held inconsistent information to direct staff to provide safe care and treatment. There was no oversight of the daily work carried out, for example the completion of food and fluid charts for people deemed at high risk. Management systems in place were not robust to ensure people remained safe.

Staffing levels were satisfactory, however on the day of our visit three agency care staff had been used due to sickness. One of the two qualified nurses on duty was also an agency worker.

People did not always receive personal care in a timely manner. Though we were informed some people had received personal care that morning, no documentation had been completed to evidence this. Turning charts and food and fluid charts were not always completed as directed in the care plan. One person was found to be very thirsty when offered a drink.

The management of the care staff including the monitoring of the completion of all charts was not sufficient.

Some rooms where found to have a strong odour of urine.

Medicines systems were not robust enough to keep people safe.

Policies were not implemented. Improvements identified in action plans were not always reflected in practice.

The governance of the service was not sufficient.

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

Rating at last inspection (and update)
The last rating for this service was Requires Improvement. (published January 2019)

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about people living in the service, the time people waited for personal care in the mornings and the amount of weight some people had lost. Other issues included poor staffing levels, poor completion of charts to monitor people's health and wellbeing. For example, food and fluid charts, turning charts and that personal care was not completed in a timely manner. A decision was made for us to inspect and examine those risks.

CQC have introduced targeted inspections to follow up on a Warning Notice or other specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

We have found evidence that the provider needs to make improvements. Please see the Safe section 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 monitor the service and 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 and the oversight of safety and risk.

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 for 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

Inspection not rated.

At our last inspection we rated this key question Requires Improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question, we had specific concerns about.

Belmont House Nursing Home

Detailed findings

Background to this inspection

This was a targeted inspection to check on specific concerns we had about safe care and treatment of people, access to emergency health care, staffing levels, safeguarding processes and the oversight of safety.

Inspection team.
The inspection was carried out by two inspectors.

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

The service had an acting manager in place, however they were not registered with the Care Quality Commission. The previous manager was no longer employed at the service, but they had not cancelled their registration. The manager currently working at the service had only been in post for three weeks. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We announced the inspection an hour before we visited to discuss the safety of people, staff and inspectors with reference to Covid 19.

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 had not requested the provider send us a provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections.

During the inspection
We met with four people who used the service. We spoke with the deputy manager, two care staff, two nurses, a catering staff member and the lifestyle coach. We also spoke with social care professionals involved with the service. We reviewed a range of records. This included eight people's care records and four medication records. We looked at one staff file. We also reviewed a variety of records relating to the management of the service including rotas, medication policy and procedure and charts in relation to peoples care.

After the inspection visit.
We continued to seek clarification from the acting manager to validate evidence found. We provided feedback and requested further information from the acting manager on 14 July 2020. We received additional information from the acting manager after the inspection.

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 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.

We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check specific concerns received about people living in the service. Concerns regarded the time people waited for personal care in the mornings and that people were left for long periods without assistance. There were concerns about the amount of weight some people had lost. Other issues included poor staffing levels and the poor completion of charts to monitor people's wellbeing. For example, food and fluid charts, turning charts and there were concerns that personal care had not always been completed in a timely manner. Medicines systems were not robust enough to keep people safe.

We will assess all of the key questions at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management; Preventing and controlling infection
At our last inspection the provider had failed to ensure that people were not at potential risk because the service had not taken steps to ensure a safe environment. For example, a door to a cupboard containing cleaning materials was unlocked and accessible to people who may have been vulnerable. Systems to prevent and control infection were not always effective. There were malodours throughout areas of the service.

We made a recommendation that the provider take steps to ensure systems to monitor and address risks associated with the environment are managed effectively.

At this inspection we found areas of the home still had a malodour.

Assessing risk, safety monitoring and management
● Staff did not always understand and know their responsibilities to keep people safe and protect them from harm. We found no evidence that people with higher needs had been checked on regularly. People were left until very late in the day and for long periods before having their personal care needs attended to. For example, we found one person in discomfort at midday. A staff member confirmed this person had not received personal care. They said this person had been provided with breakfast and a drink. However, nothing was documented to confirm this. Some people had been assessed as needing to have regular re-positioning to protect their skin integrity. Re-positioning charts had either not been completed or held insufficient detail on how to protect people's skin integrity. We found people confined to bed with either call

bells out of reach or cords that were too long and posed a potential hazard.
●People who required additional assistance and monitoring of their food and fluid intake did not have their charts completed to record if or when they had eaten and drunk. This information was not held in the main kitchen to inform catering staff of people who required a fortified diet. A fortified diet means that extra calories should be added in to meals. A staff member spoken with did not know what a fortified diet consisted of.
●People were left food to eat which did not match the correct consistently that was documented on people's records. For example, one person's record stated, 'finger food or food cut up and requires encouragement'. We found this person had been left a normal plated meal, which staff reported they had not eaten and they had only eaten their dessert. This meant that care staff and catering staff were not following the guidance in the person's care plan.
●People who required food supplements due to weight loss, did not have these evenly spaced out during the day. People received their food supplement with the main meal. This resulted in people either eating their meal or having the food supplement, not both as required.
●People did not have effective monitoring of their food and fluid intake when they were deemed as at high risk of weight loss. We found one person, considered high risk, was not having their food and fluid intake monitored. This person was not being weigh regularly. Therefore, staff could not be sure they were maintaining or gaining weight as required.
● Care plans did not show the current care needs of people living in the service. One person had a skin integrity care plan in place. This described the person as being at very high risk of developing pressure damage. It stated this person repositioned themselves. However, they had a re-positioning chart in place with no clear guidance for staff about how often they needed moving.
● People who were to have their food and drink intake monitored did not have this information clearly documented in their care plans. There was no clear guidance on what additional support people needed with their food and drink. Other people had care plans that showed they required support to maintain a healthy weight and dietary intake. However, there was no nutritional assessment or care plan in place to guide staff about the care and support people required.
● Auditing and governance systems had not always identified or addressed the concerns raised during this inspection. Audits had not identified that care records did not contain sufficient detail about people's care and support needs. Management oversight had not identified incomplete monitoring charts, or that some people had not had their daily care needs met in a timely manner.

There was no evidence that people's skin integrity had suffered as a result of the lack of monitoring. However, there was evidence people had lost weight. Failing to identify, assess, reduce and monitor risks to people was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to ensure that oversight was effective in improving the safety and quality of the care people received. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Using medicines safely
●The service had a new Medication policy in place. However, the provider was not aware of all policy contents of the National Institute for Health and Care Excellence (NICE) guidance. NICE clinical guidelines are recommendations, based on the best available evidence, for the care of people by healthcare and other

professionals. Clinical guidelines enable those caring for people to reassure them that they are following evidence-based practice. This meant that people's medicines were not always managed in line with best practice. For example, competency checks on staff had not been carried out to ensure staff were administrating medicines safely. There was also no guidance for staff to make consistent decisions about when to give a medicine prescribed to be given 'when required'.

● Two people were prescribed 'as required' medicines for their behaviour. There was no record or behaviour plans in place. There was no detailed information recorded to say why they required this medicine, how often it could be given and what behaviours they displayed.

● Though the policy clearly showed the process the staff were to follow when any medicines were refused, we found a nurse had made a hand-written note on a paper towel that a person had refused their medication and attached this paper towel to their MAR (Medicine Administration Record) sheet.

● There were suitable arrangements for ordering, receiving, storing and disposal of medicines. However, it was noted that the service had excess stock of some medicines and these had not been correctly documented to confirm the number held at the service.

● We found that the staff audited the number of medicines remaining in stock after each 'as required' medicine had been administered. However, we found some medicines had not been documented correctly and recorded incorrect amounts.

● Medicines were being audited regularly with action taken to make ongoing improvements. However, audits had not picked up the above issue. We found people prescribed 'as required' medicines did not have a protocol in place providing staff with guidance of how and when it should be used. The registered nurse on duty took immediate action to resolve the excess stock issue.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate medicines 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.

Systems and processes to safeguard people from the risk of abuse

● We found documented in one person's care plan, a completed body map which showed bruising. There was no explanation or evidence to say this had been investigated or passed onto the management of the service. There was no evidence that a safeguarding alert had been raised. We spoke to the deputy manager about this. This issue had not been brought to their attention. This was raised with the local safeguarding team.

Preventing and controlling infection

● Following the Covid-19 outbreak staff had full access to PPE. The service had no cases of Covid-19 within the home. There was clear guidance for staff coming on duty to wear PPE. There was also a policy in place which included checking visitors temperature on entry, hand sanitizers to use and that all visitors to the home must wear face masks. Though some areas, mainly bedrooms, had a malodour the communal areas were found to be clean.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate medicines safety was effectively managed. This placed people at risk of harm. There was no evidence that people's skin integrity had suffered as a result of the lack of monitoring. However, there was evidence people had lost weight.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance At our last inspection the provider had failed to ensure that oversight was effective in improving the safety and quality of the care people received.