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 effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Belgrave Court Residential Care Home provides accommodation and support with personal care for up to 30 older people, some of whom may be living with dementia. At the time of this inspection there were 26 people using the service.

People's experience of using this service and what we found
The service was not well led. Governance arrangements continued to be ineffective and could not demonstrate how people were safe, or how their care and support needs were being consistently met. This was the fourth consecutive inspection where the provider had not achieved a rating of good.

People's safety and welfare was compromised. People's health needs had not always been addressed as requested by healthcare professionals, and there was a delay in people receiving healthcare treatment.

Risks to people were not mitigated and people were not safeguarded from abuse and improper treatment.

The providers systems had failed to highlight the gaps in staff's knowledge about the monitoring of peoples health and Diabetes management, and safe evacuation in the event of an emergency.

Peoples care plans and risk assessments did not contain accurate information about their healthcare risks, contained conflicting information, and did not reflect their current needs.

People were not always supported to receive their medicines as prescribed in a safe way. Recruitment processes were not robust which put people at risk of being supported by unsuitable staff.

Further work was required to ensure government guidelines for working safely in care homes during the COVID-19 pandemic were implemented, adhered to, and appropriately monitored.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff did not always receive effective training to support their role.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 10 May 2021). There were breaches of Regulations 12 (Safe care and treatment), for which we served an Urgent Notice of Decision to place

conditions on the registered providers registration, and Regulation 17 (Good governance).

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

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

At a previous inspection published on 12 November 2019 we recommended the provider reviewed staff training, taking into account best practice guidelines. The provider had not made improvements.

At a previous inspection published on 12 November 2019 we recommended the registered provider ensured that where people lacked capacity to make a decision, the principles of the Mental Capacity Act 2005 are followed and recorded. The provider had made some improvements.

Why we inspected
We carried out an announced focused inspection of this service on 17 March and 1 April 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve Safe care and treatment, and Good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe, effective and well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings 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 COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

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 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, safeguarding service users from abuse and improper treatment, fit and proper persons, and governance of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

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.

The overall rating for this service is 'Inadequate' and the service is therefore 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? The service was not safe. Details are in our safe findings below	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

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 Care Act 2014.

Inspection team
The inspection was completed by two inspectors.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave the service short notice of the inspection on our arrival on the first day. This was because we had to gather information on the home's current COVID-19 status and the provider's procedures for visiting professionals. We informed the management we were returning on the second day.

What we did before 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 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. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with nine members of staff including the registered manager, compliance manager, two senior care workers, two care workers, a cook, housekeeper and activity worker.

We reviewed a range of records. This included 12 people's care records in part, and multiple medication records. We looked at two staff files in relation to recruitment. 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 registered manager sent us further information which included an action plan, and safeguarding information.

Inadequate

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. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

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.

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

Using medicines safely

- Medicines were not managed safely.
- We identified discrepancies with the administration of time sensitive medicines. One person was prescribed three medicines that were required to be taken 30 to 60 minutes before food, with or just after food, and with food or a meal. It was unclear from the medicine administration record if the person was receiving these medicines in line with the prescriber's instructions as they were recorded to be given in a 'morning,' with no specific times. We spoke with a member of staff who told us these medicines were administered all at the same time. This was not in line with prescribing instructions.
- The same person was prescribed a medicine, 'as and when required' [PRN]. There was no PRN protocols to inform staff how the person may present if they required their prescribed PRN medicine, and there was no record of the number of tablets given to the person when the PRN was required.

There was a failure to ensure the proper and safe 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.

Preventing and controlling infection

- We were not assured that the provider was doing all they could do to prevent people, staff or visitors from catching and spreading infections.
- We observed visitors in the home were not always wearing face coverings in line with government guidance.
- We reviewed 12 peoples care records and were unable to see any care plans or assessment of risk to people in relation to COVID-19, and its transmission. Following the inspection, the registered manager shared evidence of individual risk assessments for COVID-19 for three people. However, we did not receive any additional evidence to demonstrate risk had been considered for the other nine people whose care we had reviewed.
- We reviewed two staff files. There was no assessment of risk completed in relation to COVID-19 in line with

government guidance. Following this inspection we were provided with a risk assessment for one member of staff who had underlying health conditions. This was dated following our inspection. We were not provided with assurances this risk had been considered and acted upon, until CQC had requested this information.

Assessing risk, safety monitoring and management

● Risks to people were not always identified, assessed and mitigated.

● Risk assessments and care plans were not in place to inform staff how to manage and mitigate risks associated with people's needs and health conditions.

● Staff did not respond to health professionals' requests to ensure people received the appropriate care and treatment for their needs. One person received an appointment of a planned operation.. Daily records we reviewed recorded instructions from the hospital to cease some of the persons medicines prior to the hospital admission. This instruction was not effectively communicated with staff and the person received these medicines. This meant the operation had to be cancelled, and the person was unable to receive the appropriate treatment.

● Accident and incident forms were poorly completed. This had been identified by the registered manager; however, we saw no evidence of any action take to address this with staff.

● People were exposed to the risk of harm in the event of an emergency as risk was not appropriately managed. Information stored at the service to support people in the event of an emergency was missing, and not easily accessible. When we asked staff about people's emergency evacuation plans one said they "Hadn't seen these yet as only been a member of staff a few months," another told us, "I have not seen any personal evacuation plans. I am not aware of where this information is."

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.

● We raised the immediate risks from the lack of specific care plans and risk assessments with the management on the first day of our inspection, following which action was taken to address the concerns and ensure people's safety.

● Immediate action was taken by the management to ensure peoples safely in the event of an emergency. All emergency evacuation plans were either implemented, updated, and made accessible to staff in a 'grab pack.'

Systems and processes to safeguard people from the risk of abuse; Learning lesson when things go wrong

● Appropriate referrals were not made to the responsible safeguarding authority, and therefore, placed people at risk of harm.

● No action had been taken to investigate the missed/delayed healthcare appointments for two people. This meant lessons had not been learnt or shared with staff and measures were not put in place to reduce the risk of possible harm.

● Robust procedures and processes to prevent people using the service from being abused by staff were not in place as neither of these missed/delayed healthcare appointments had been alerted to the local safeguarding team until requested by CQC on 20 December 2021.

The provider had failed to ensure that people were protected from the risk of harm. 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.

● People told us they felt safe living in the home. One person said, "I am happy here, l feel safe because know all the carers and there is always someone around." Another told us, "They [staff] are very good to us here, we get well looked after. They care for us well."
● The registered manager confirmed two referrals had been made to the local safeguarding authority following the inspection.

Staffing and recruitment
● Staff recruitment was not robust.
● Staff had not always been safely recruited in line with the providers policy. Appropriate checks were not completed to ensure staff were of a suitable character to work with vulnerable people.
● The training matrix we reviewed did not include one member of staff, and another member of staff had no recorded training in some subjects including moving and handling, health and safety and safeguarding. This did not provide assurance staff were suitably prepared to undertake the requirements of their role.

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 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection of this domain in August 2019 we rated this key question requires improvement. The rating for this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support;

- People's needs, and risks were not always included within their care plans. This meant staff lacked critical information about the people in their care.
- Care plan reviews failed to adequately review and identify changes in people's needs and care. This resulted in information about some people's needs being incomplete and inaccurate.
- People were not supported to access healthcare services and medical treatment in a timely manner.

People's needs were not adequately reflected within their care records to ensure the care provided was informed by their needs and effective. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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.

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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorizations to deprive a person of their liberty had the appropriate legal authority and were being met.

At a previous inspection published on 12 November 2019 we recommended the provider ensured that where people lacked capacity to make a decision, the principles of the Mental Capacity Act 2005 were followed and recorded. The provider had made some improvements, however further work was needed to ensure these improvements were fully embedded. This has been reported on further in the well-led section of this report.

● Peoples capacity to consent to care and treatment had been considered in line with the Mental Capacity Act 2005.
● Where best interest decisions had been made documentation was not always fully completed to show what discussions had taken place in relation to people's care and treatment.

Staff support: induction, training, skills and experience

At a previous inspection published on 12 November 2019 we recommended the provider reviewed staff training, taking into account best practice guidelines. The provider had not made improvements.

● Staff did not always have training to support them to meet people's health needs. For example, people at the service had a diagnosis of Diabetes however, we saw from the training matrix staff had not received Diabetes training. Staff we spoke with did not have sufficient knowledge of who had Diabetes. This placed people at risk of not receiving timely care in line with their needs which may have resulted in avoidable harm.

Supporting people to eat and drink enough to maintain a balanced diet
● Monitoring charts for people's food and fluid intake were not completed consistently.
● Care plans for people with dietary monitoring requirements contained conflicting information.

Adapting service, design, decoration to meet people's needs
● The home was accessible for people's needs.
● People had access to communal spaces, quiet areas and a front garden which was suitable for their needs.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to 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.

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 (Regulated Activities) Regulations 2014.

No improvement had been made at this inspection and the provider continued in breach of regulation 17.

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

- The provider had failed to maintain sufficient and accurate oversight of the service. Risk management was ineffective, and regulations were not being met. This meant people were not always in receipt of safe care.
- The provider and registered manager had failed to ensure all potential safeguarding concerns had been reported to the local safeguarding team for investigation and to mitigate future risks to people.
- Monitoring of care plans had failed to identify risks associated with people's care had not always been identified or managed well.
- Records related to people's care were not always detailed or complete. This meant the provider could not demonstrate all planned care had been provided safely, in line with people's individual risk management plans. For example, records to evidence monitoring of food and fluids, and the management of Diabetes.
- The provider's medicines audit had not been effective in identifying the concerns we found in relation to medicines not being administered as prescribed.
- Organisational policies and processes had not been consistently followed in relation to the safe recruitment of staff.
- The provider had failed to ensure government guidelines for working safely in care homes during the COVID-19 pandemic were adhered to.
- Following a previous inspection we recommended the provider made some improvements to follow and record the principles of the Mental Capacity Act 2005, where people lacked capacity. Some improvements had been made, however the records maintained did not always follow good practice.

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.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Staff told us they felt able to share concerns with the registered manager and they were supported in their role. Staff said the registered manager had supported them through the Covid-19 pandemic.
- The provider has acknowledged improvements are required at the home and are working with us, the Local Authority to make these improvements.