Mrs Margaret Mary Gregory

# Belgravia Care

## Inspection report

Belgravia Court
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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |
| Is the service safe? | Inadequate |
| Is the service effective? | Inadequate |
| Is the service caring? | Requires Improvement |
| Is the service responsive? | Inadequate |
| Is the service well-led? | Requires Improvement |

## Overall summary

This inspection took place on 03 March 2015 and was unannounced.

Belgravia Care Home is situated on the seafront at Blackpool. The home is registered to accommodate up to 19 older people, people with learning disabilities and people living with dementia, who require assistance with personal care. At the time of our inspection there were 17 people who lived at the home.

The ground floor was generally unused except for an activity room. The first floor had offices and three communal areas, including dining, lounge and crafts rooms. Bedrooms were situated on the upper floors of the home. All rooms were single occupancy with en-suite facilities. There was a passenger lift for ease of access and the home was wheelchair accessible. There was parking to the front of the building.

There was no registered manager in place. The previous registered manager had resigned at the end of 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

# Summary of findings

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. A new manager had commenced working in the home and had started the process to apply to become the registered manager.

At the last inspection in September 2014, we asked the provider to take action to make improvements to how staff were recruited, people's medicines were managed and how records were maintained. We carried out enforcement action, serving a warning notice in relation to how staff were recruited, which the provider was required to meet by 14 December 2014. The registered provider provided an action plan to the Care Quality Commission (CQC) which showed they would be compliant with regulations relating to how people's medicines were managed and how records were maintained by Mid November 2014.

At this inspection we observed improvements had been made to how staff were recruited and the service had met the warning notice. However, we found that they had again not met the requirements in relation to the management of people's medication and the maintenance of records. In addition there were new breaches of the regulations. These related to the provider not assessing or taking appropriate action to keep people safe. There was not enough suitably qualified, skilled and experienced staff. People were not provided with good nutritional support and infection control was poor. Suitable arrangements were not in place to enable people to participate in and make decisions about their care and treatment or in obtaining consent of people in regard to their care and treatment. The service did not work in cooperation with others through sharing information when people were moving from the home. Suitable arrangements were not in place for assessing, and monitoring the quality of the service and acting upon their findings.

During this inspection, we could not gain access to the home for over 45 minutes on arrival. Staff explained they were unable to hear either the doorbell or the telephone. This would have been a problem if they were unable to be contacted in an emergency.

People we spoke with told us that staff were kind and caring. They told us they were happy and satisfied with life in the home. One person told us "The staff are all good. They look after me." However it was evident from our observations that care was not safe and people who had high care needs were left sitting unattended, with little stimulation or attention for long periods of time. We saw there were not enough staff available to provide safe and appropriate care and support and to provide social and leisure activities. This meant social and leisure activities were limited and people spent a lot of time without meaningful activities.

We have made a recommendation that the registered provider develops a person centred way of working, and provides suitable activities.

Risk assessments were not always in place and where they were they were not informative. They highlighted risks but did not give staff guidance on how to reduce any risks. Where people had behaviour that challenged the service, there was no guidance for staff or strategies to reduce behaviours or diffuse situations. Where staff did not have sufficient knowledge to support people safely this put people at risk of harm.

We looked at how medicines were managed. We saw medicines were not always given safely. Failing to give people their medicines properly placed their health and welfare at unnecessary risk.

There were poor infection control practices in the home. When we looked around the home we saw furnishings, carpets and equipment were unclean and unhygienic.

Staff told us they had access to training and were being encouraged to develop their skills and knowledge by the new manager. However there were areas of training including safeguarding vulnerable adults and managing behaviour that challenged, where staff were lacking in skills and knowledge. Training information for newer staff was not available.

Although people told us they enjoyed their meals and had plenty to eat, information about each person's nutritional needs, likes and dislikes was not available. Some equipment to assist people at mealtimes was in place but other equipment was not available or was unsuitable.

Staff had only limited understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We saw that staff had not determined

# Summary of findings

people's capacity to take particular decisions. There was conflicting information in care records relating to the mental capacity of one person. Although several people had DoLS in place staff had not consistently followed the conditions of the DoLS approval. One individual was being restrained without proper authorisation.

The home was not designed or adapted to effectively support people living with dementia or for people with learning disabilities to develop independent living skills.

We have made a recommendation about the registered provider ensuring staff have guidance about best practice in dementia care and learning disabilities.

We looked at care records. These varied, some were informative, and others had significant pieces of information missing and had not been updated in some areas. Although people and where appropriate their relatives had been involved in initial care plans, this had not continued. This meant people were not involved in updating and developing their care plans.

We were contacted prior to the inspection by professionals who were involved with people where moves to other services had been planned. They told us that the registered provider and previous management team had discouraged moves and were unwilling to share information when people were moving elsewhere. This put people at risk as the staff in their new homes did not have all the information they needed.

There were procedures in place to monitor the quality of the service. Audits were being completed by the registered provider. Yet the audit systems were not picking up the areas of concern identified during this inspection process.

Staff recruitment had improved since the last inspection. We found that it was robust, with all necessary checks carried out. This meant it reduced the risks of unsuitable staff working in the home.

People told us that their views were sought on a regular basis. There were surveys about the person's experience of living in the home and residents meetings. These gave people the opportunity to voice their opinions. They told us they had no complaints about the home and were happy there. They told us they were aware of how to make a complaint and felt these would be listened to and acted upon.

Staff were aware of people's individual needs around privacy and dignity. When they interacted with people they spoke with people in a respectful way. A relative said of their family member, "She is always treated with dignity and respect at all times". They told us staff were welcoming to them and there were no restrictions on visiting.

A large part of the staff team had changed in recent months. There had been a change of manager, the previous manager left the home at the end of December 2014. A new manager had commenced in post in January 2015. People told us the new manager was approachable and willing to listen to people. One person said, "She is nice." Relatives were also complimentary. A relative said, "I was worried about lack of staff and did feel that I could speak to the manager – I did feel listened to."

We found a number of breaches of the Health and Social Care Act 2008 and associated Regulations. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

## 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.

Inadequate 

Although people told us they felt safe staff were not providing safe and appropriate care to all people in the home.

Staffing levels were not always sufficient to provide safe care. People who had high care needs, were left with little stimulation or attention for long periods of time.

Medicines were not always administered and managed safely.

Infection control practices did not ensure cleanliness or reduce the risk of cross contamination.

**Is the service effective?**
The service was not effective.

Inadequate 

Procedures were not in place to enable staff to assess peoples' mental capacity, where they were unable to make decisions for themselves.

Although the provider had registered to support people who lived with dementia or learning disabilities, the home was not designed or adapted to enable people to be as independent as possible.

Staff were not trained to effectively support people with behaviour that challenged the service and they did not have sufficient skills and knowledge about safeguarding vulnerable adults and the mental capacity act.

People told us they liked the meals. However there was little information in care plans about people's nutritional needs and people who were more dependent did not have appropriate equipment to assist them at mealtimes.

**Is the service caring?**
The service was not always caring.

Requires Improvement 

Some people were not provided with appropriate care and attention. People were left unsupervised and unsupported at times.

Although people were involved in planning care on admission, this did not always continue and they were not involved in developing and updating their care.

Staff spoke with people in a respectful way and people said that staff respected their privacy and dignity.

**Is the service responsive?**
The service was not responsive

Inadequate 

# Summary of findings

Although care plans and risk assessments were completed soon after admission, some important information was not in place.

The registered provider did not always work in co-operation with others and share information when people were moving from the home.

There were limited social and leisure activities available so people spent a lot of time inactive and without people engaging with them.

**Is the service well-led?**

**Requires Improvement**

The service was not always well led

Although audits were carried out regularly, the audit systems were not highlighting the areas of concern identified during this inspection process.

One person admitted to the home presented with mental health conditions, which Belgravia Care was not registered to provide care and support for. The management team had not trained staff to provide care for this individual.

People felt supported by the new manager and felt that they had made positive changes to the home.

# Belgravia Care

**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 checked 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 3 March 2015 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist advisor who had experience of the mental capacity act and providing services for people with mental health conditions and people with learning disabilities, 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. The expert by experience, had experience of services that supported people with learning disabilities.

Before our inspection we reviewed the information we held on the service. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who lived at the home. We also checked to see if any information concerning the care and welfare of people living at the home had been received.

We spoke to the commissioning department at the local authority and contacted Healthwatch Blackpool prior to our inspection. Healthwatch Blackpool is an independent consumer champion for health and social care. This helped us to gain a balanced overview of what people experienced whilst living at the home.

During our inspection we spoke with a range of people about the service. They included the newly appointed manager, five members of staff on duty, seven people who lived at the home, two relatives and health care professionals. We spent time observing the care and support being delivered throughout the communal areas of the home. 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.

We looked at the care records of five people and the medicine records of 10 people. we also looked at the previous eight weeks of staff rota's, recruitment records for six staff, the training matrix for all staff, and records relating to the management of the home.

Inadequate

# Is the service safe?

## Our findings

People told us they felt safe living at Belgravia and were happy there. One person said, "I love it here. Yes I am safe. The staff always look after me." However this did not always reflect our findings.

We arrived on our inspection at 5.45am. We did this because we had concerns that the home was not providing safe staffing and care during the night shifts. On arrival we rang the doorbell and because it was early in the morning, we also telephoned to inform staff we were outside the home. As no-one answered, we continued to ring the doorbell and telephone the home at least twice a minute for over forty five minutes.

A member of staff answered the door at 6.35am. They told us that they had been busy with a person who lived in the home and had not heard us. We later learnt that staff could not hear the doorbell when they were on the higher floors. We were told that staff were supposed to carry a telephone with them around the home but they had not done this. This meant CQC inspectors were unable to gain access when they required this. This showed that staff may not be contactable in an emergency. This could place people at risk from harm because staff were not always contactable in an emergency, such as in a need to evacuate the home.

While waiting at the door we saw that a drain cover was missing in the doorway, leaving a hole approximately 15 cm across. This was a risk to people as they entered or left the home. When we toured the home we checked several windows to see if restrictors were in place. We found one restrictor opened to an unsafe width, placing people at risk from falling out. We told the manager of this so she could take appropriate action.

There had been several safeguarding alerts and whistle blowing concerns raised about the service in the previous twelve months. These related to care practice in the home, vulnerable people leaving the home without staff support and staffing numbers and competencies. We saw on the inspection that there were issues in these areas.

Risk assessments were not informative. They highlighted risks but did not give staff guidance on how to reduce any risks. One person on a short stay only had a risk assessment completed relating to medication. This was brief and uninformative. There was no information in the care plan relating to the person's medication. One person was at possible risk from a person known to them. There was not an informative risk assessment in place. Neither were there any strategies in place for managing this or to reduce the risks.

Another person had been getting up frequently during the night. The person had had an electronic pad outside their door to monitor them leaving their bedroom, as part of the conditions of a Deprivation of Liberty Safeguards (DoLS) authorisation. Staff had changed this to using a bed rail without regard to the conditions. This bedrail meant the individual was being restrained without proper authorisation. This was additionally excessive because staff told us the individual was no longer able to get out of bed. The conditions of their DoLS had not been reviewed to demonstrate this change and meant the person was at risk from unsafe and inappropriate care.

We talked with staff about how they supported people whose behaviour may have challenged the service. They told us they had not received guidance in managing behaviour that challenged. One member of staff said, "We just use common sense". This meant that the responses to behaviour that challenged the service were not planned or consistent. One person expressed concern and fear about the behaviour of another person who lived at Belgravia Care saying they were scared when the person was angry. They felt unsafe when the person was angry.

We looked at the care plan of three people whose behaviour challenged the service. In each file recorded under behaviour management strategy was, 'Occasionally presents behaviour that can be predicted and managed by trained staff who are able to maintain a level of conduct that does not pose a risk to herself or others'. There was no further explanation. Where behavioural management strategy forms were in place they were poorly completed. Staff failed to identify or record triggers for specific behaviours, unless these were obvious, such as visitors leaving the service.

Of the three files, one file had no information about what the behaviour was or how to manage it. Another file stated the person got angry towards staff usually triggered by staff assisting the person to eat or to dress. The only intervention was recorded as 'the person would threaten to hit out so just sit next to the person and reassure'. This was not an informative plan to help staff understand the individual's needs. The third file showed three broad areas of behaviour or risks. The interventions only stated 'one to

one staff to reduce the risk of retaliation'. There was no guidance or strategies to reduce behaviours or diffuse situations. In addition the staffing advice was out of date as the care plan referred to different staffing support. The information in these files did not inform staff of how they should support the person effectively and did not keep people safe.

Behaviour records showed that 242 entries had been made over a nine month period for one person recording a variety of different behaviours displayed. The behaviour records completed had 'no' or 'very occasional' triggers identified followed by a statement "no action required". This person had been assessed as being at 'extreme risk' from others as well as posing an extreme risk to others and the records showed they required constant support and supervision to reduce the risk. We observed this support was not provided during the inspection.

Accidents and critical incident reports had not been audited to highlight the number of falls people had. This meant suitable arrangements were not in place to identify and analyse accidents and use the data to inform practice. This left people at risk of injury. Falls were not managed safely. We saw that there were 13 accident/incident forms completed for one person over a seven month period, all for falls or the person being found on floor. There were no themes or patterns identified around the reasons for the falls. There were no action plans in place to reduce the risks of falls for this person.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to protect people against the risks of abuse

Another person was assessed as high risk of falls and had a falls risk assessment in place. This was managed more appropriately. A referral had been made to the falls team in the area who advised on changing the bedroom around and advised on buying the correct shoes in order to minimise the risk. This was done and there was a reduction in falls as a result.

Staff we spoke with told us that they would report any suspicions of abuse. They were able to talk through the steps they would take if they became aware of abuse. However they were unaware that restraint of a person by the use of a bedrail may have been a safeguarding issue. This showed us that although they had some understanding of abuse, this was limited and did not fully reduce the risk for people from abuse.

We looked at how the home was being staffed. We did this to make sure there were enough staff on duty to support people throughout the day and night. We had received concerns about staffing numbers and staff skills before the inspection. We had been informed before the inspection that there was only one waking night staff plus a sleep in staff on nights.

On arrival in the home we saw there were two staff on the night shift. We checked that both staff had been on waking nights. They told us they had and the rota reflected this. However looking at the rota and speaking with staff we saw that for a period of twelve nights in February 2015 only one waking plus a sleep in staff were on duty at night. In a building the size, design and layout of Belgravia care two staff working in the home at night, regardless of client needs would stretch staff. Only one member of waking staff was unsafe. In addition to caring for people, staff were expected to carry out laundry and cleaning duties. The laundry was on the ground floor. Bedrooms were on the upper floors.

People who lived at Belgravia had a wide range of care and support needs. A small number of people did not need constant supervision and were relatively independent within the home. However, staff told us that at least 5 people needed close supervision and the support of two staff to provide care. We observed at least a further eight people needed frequent supervision and checks. Some people were able to spend time around the home, in communal areas and their bedrooms as they wanted. We were told other people were not and had to stay in the communal areas throughout the day. We focussed on one person who we were told was not allowed back in their bedroom during the day. This person remained at a dining table in their wheelchair from approximately 9am until when we left the home at 7pm.

We were told before the inspection that staff did not always answer call bells or they took a long time to answer. Although we heard call bells during the inspection, as bedrooms were on several floors it was not possible to see whether these were always answered quickly. However the calls did not continue for long. People said staff did not always respond quickly when they called for help. We

Inadequate

# Is the service safe?

asked one person if they were satisfied with the staffing levels. They told us, "Yes. I do think there are enough staff." but then went on to say "I used the call bell twice – I am not supposed to because it is for emergencies – nobody came quickly and when they did come they told me not to use it. I wasn't in trouble I just wanted to press the button".

We looked at rotas from January 2015 to the inspection in March 2015. During the day staffing varied but averaged at three staff between 9am and 5.30pm. This included cooking and cleaning duties. There were usually only two staff from 5.30pm. In addition the manager, who was not registered with CQC, told us she worked Monday to Friday 9am – 5pm. However this was not recorded on the rota.

We asked people and relatives before and during the inspection, if they were satisfied that there were enough staff available to provide safe and appropriate support. A relative told us, "I have never had any trouble with the staff – just not enough of them – my [family member] does not have the support required" Another relative said, "I have seen lots of times when there are not enough staff about – and people have been needing help."

A member of staff told us, "It's a bit short of staff at the moment because some staff have left, but new ones have been recruited so this will get better." The staff we spoke with before and during the inspection had mixed views about whether there were enough staff to meet people's needs. However several staff commented that it was difficult to meet everyone's care needs with the staff numbers available. They acknowledged they did not usually have time to support people on activities or to go outside the home.

We asked the manager if staffing levels were reviewed to make sure they met people's needs and dependency levels. She told us that she had increased staffing during the day when she started working in the home. She said she discussed this with the provider. However staffing had not been reviewed to reflect the needs of people or when numbers of people increased.

This is a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not deployed sufficient numbers of suitably qualified, competent, skilled and experienced persons to keep people safe.

We looked at how medicines were managed. We observed a medicines round and saw that the member of staff was signing for medicines before they had given them to people. This meant that they had signed before they knew whether each person would take their medicines. One person was given medication covertly. There had been a best interests meeting carried out regarding this involving all relevant people and a record of this was kept. However the person was given their medicines in food which staff gave them. Staff did not observe that the medicines were taken by the person. They left them unattended, with the medicines in the food with other people close by. This meant that they did not know if the person or anyone else had taken the food with the medicines in it.

There were no protocols in place to provide staff with information about under what circumstances 'when necessary' (PRN) medicines were to be given. This meant that it was not clear why people needed to take 'when necessary' medicines. Where there was a choice of one or two tablets to be given, it was not always clear how many tablets people had been given. This would affect how many tablets could be safely given.

Medicines checks were carried out daily. In addition comprehensive medicines audits were completed monthly to assist with improving medicine administration. The manager was following up and taking action over unsafe administration. However it was not clear if the manager was also observing staff administering medicines.

People's medicines were not always ordered in good time. This meant people did not always have the medicines they needed. Two people had run out of medicines for two days. They usually took these twice daily for reducing specific health symptoms.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not managed medications safely.

We saw that medicines were checked on receipt into the home, and stored and disposed of correctly. Longer term staff had been trained in the management of medicines. The manager told us she was planning to arrange training for newer staff.

There was evidence of one person being supported to have her tablets, which she was very reluctant to take, in a very

# Is the service safe?

appropriate, respectful way. The individual was obviously distressed at the amount of tablets she had to take and the staff member gave her time and encouragement to take them in a caring and supportive way.

Concerns had been raised about the hot water for showering or washing being turned off from 7pm – 7am each night. When we arrived we asked about the hot water. A member of staff initially said this was turned off between 7pm, and 7am. We asked how staff assisted people with personal hygiene during this time. We were told staff showered people as the shower was electric. The member of staff then said that the hot water was not turned off at night. We checked the hot water in several rooms. Although the water took a while, it did eventually run warm.

We were concerned with the cleanliness of the home. There were poor infection control practices. When we looked around the home we saw infection control issues where furnishings, carpets and equipment were unclean and unhygienic. We found dirty linen had been left on the floor of two bedrooms. Window sills in some rooms were dirty and stained. Several rooms smelt strongly of urine. Mattresses and bed linen in several rooms were stained and dirty and other beds smelt strongly of urine. One person was laid in a bed with a stained and dirty mattress which smelt very strongly of urine and faeces. The carpet also had faecal matter in some areas of it. Another person had small flecks of faecal matter on their armchair. Three of the toilets had dried faecal matter around them. One person's curtains were stained and streaked with a dried liquid. Most chairs in the bedrooms were stained and dirty with ingrained dirt, as were chair arms in communal areas. Some crockery in use was unclean. There was a smell of urine in bedrooms even though the beds had been stripped. There was a rubber mat on the floor of one bedroom. Staff told us this was because the person got out of bed and urinated on the floor in the same spot. The staff said that the mat was easier to clean. The carpet smelled strongly of urine.

Although we saw that staff wore personal protective clothing when involved in personal care or at mealtimes. We noted that staff did not wipe people's hands or face or give them the opportunity to do so before or after meals.

The inspection team looked around the home in the morning and also checked these areas later in the inspection. These areas were still unclean. The manager said that she was in the process of recruiting a cleaner and that staff were carrying out the cleaning as well as their care duties. Clearly this was not working as the home was unclean and unhygienic.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not ensured safe infection control practices

At the last inspection we served a warning notice as recruitment had been unsafe on that and the previous inspection. On this inspection new staff had been recruited safely. We looked at the recruitment and selection of seven members of staff. People were protected from unsuitable staff working in the home because safe recruitment procedures were followed. Application forms were completed and interviews had taken place. Any gaps and discrepancies in employment histories had been followed up. This meant the manager knew what work the prospective member of staff had previously been doing. References had been received before staff were allowed to work in the home and Disclosure and Barring Service (DBS) checks had been received before new staff were allowed to work in the home. These checks were introduced to stop people who had been barred from working with vulnerable adults being able to work in such positions. One member of staff who had recently been recruited said, "My recruitment was very good and well done. I didn't start before they got my DBS. I have a proper induction where I shadowed other staff. It was really good."

Inadequate

# Is the service effective?

## Our findings

People told us they liked the food. One person said, "The food here is good. I was having two puddings and put on a stone in four weeks. The staff were weighing everyone and noticed this so they put me on a diet – one pudding." Another person told us, "I have lived here quite a bit now. We have a choice of food now, we never used to – and we get enough."

Specific dietary needs and food likes and dislikes had not been identified in care plans. This meant that care staff, particularly those new to the home, did not know people's likes and dislikes and were not familiar with each person's dietary needs. This did not follow current good practice for people with learning disabilities and / or dementia.

Staff did not encourage people to socialise at mealtimes. Some people were sat at tables alone, and there was no encouragement for people to talk to each other or to the staff. The food was brought out of the kitchen at a very slow, staggered rate. One person was clearly unhappy and complained that everyone had their food and that they hadn't started theirs yet.

The specialist advisor ate with people to experience lunch time at the home. The lunch sampled was at a good temperature and was satisfactory. However the choices were limited. Several people had pink 'Minnie Mouse" cups at lunch time which were age inappropriate. One person living with dementia could not see the juice in the pink cup and so poured it out over her dinner plate because they thought it was empty. Another person had a lipped plate with their main meal lunch that assisted them to eat more independently. However, the pudding was given to them in an ordinary bowl that they struggled with.

We saw that breakfast time was flexible and people were provided with their choice of breakfast once up and dressed. However we observed that staff were carrying out other tasks and not always observing whether people were eating their meal or whether they needed assistance. There was no evidence of people having access to snacks or drinks independently outside of meal times.

We talked with the cook. The cook showed us the menu's in place. The cook understood people's individual dietary needs and preferences. They told us, "I go round and chat with new residents to check their likes and dislikes. I also speak with the residents regularly to see if they like the food or if we need to change anything." We were told when the cook was not working the senior care staff cooked the meals. This limited the time they had for other duties and reduced staffing around mealtimes.

This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not always ensured people's nutritional needs were met.

The staff we spoke with told us they had some access to training and were encouraged by the new manager to develop their skills and knowledge. The manager provided us with a training matrix. There were fifteen names on the matrix. It did not include the manager. Three new staff did not have any training information on the matrix. The manager told us she would email this to CQC but it did not arrive, so we were unable to see whether they had received training.

From the information on the matrix we could see that some staff had received recent training including dementia/lets respect, diabetes, fire safety, safeguarding vulnerable adults, food hygiene and Mental Capacity Act. This meant that some staff had the skills needed to care for people. However other staff did not.

New staff spoken with told us they had received a good induction. However there were no records available to confirm this. According to the training matrix, only nine of the fifteen staff had received safeguarding training and eight staff received Mental Capacity Act training. Only eight staff had received training about learning disabilities despite the home supporting around eight people with learning disabilities when we inspected. Three staff had received breakaway training, which teaches staff how to avoid or how to 'break away' from an assault. However no staff had received training in how to manage and diffuse anger and behaviour that challenges the service. This left people in the home and staff vulnerable.

Six staff had completed national qualifications in care. Twelve staff had received fire training. These assisted those staff to support and care for people. Twelve staff had received dementia awareness training but this training had not resulted in good dementia care practices. We had received concerns before and during the inspection regarding the ability of staff to support people

appropriately. When we discussed dementia care with staff and observed care, staff did not have the skills and knowledge to provide specialist dementia care. They were not equipped to provide for the complex needs of people with dementia. Some relatives expressed concern over dementia care in the home. However one relative told us "[My family member] is happy here – yes – I do think the staff here know about dementia."

We saw that longer term staff received formal supervision. Supervision is where individual staff and those concerned with their performance, typically line managers, discuss their performance and development and the support they need in their role. It is used to assess recent performance and focus on future development, opportunities and any resources needed. One member of staff said, "We get supervision. I had one two weeks since." Another member of staff told us, "Yes we have supervision every couple of months." Staff told us this was one of the ways that the management team supported and encouraged them.

However one member of staff said I haven't had supervision yet as I am still quite new and you don't get supervision for three months." New staff were the least familiar with the home and care practices within the home. Not receiving supervision meant they were not provided with the skills and knowledge they needed to fulfil their role. We asked staff if they had records of their discussions in supervision. They told us they didn't have written copies of the supervisions. This meant they could not refer to issues discussed.

This is a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not made suitable arrangements to provide staff with appropriate training.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the management team. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

There was evidence of generic statements regarding consent in people's care files. These were general statements that the individual had provided written consent for ongoing care and treatment. This was not in line with the MCA, which requires decision specific consent or best interests' decisions. Clear individual procedures were not in place to enable staff to assess peoples' mental capacity. This meant should there be concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk.

Some staff had little knowledge about MCA and struggled to answer questions about how they asked people about decision making. Other staff were more aware. One member of staff told us, "We check capacity about minor things by having a chat, getting to know them and asking a few questions. We also check with the social worker, GP and relatives and have a best interests meeting if necessary". However we saw that staff had not determined people's capacity to take particular decisions in relation to their family and life choices. One relative was concerned that staff had not spoken with them about mental capacity. "[My family member] has dementia, has no capacity. No one has ever talked to me about the Mental Capacity Act from Belgravia Court Care Home." This meant that relevant people had not been involved in decision making about mental capacity.

The management team had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We spoke with the management team to check their understanding of MCA and DoLS. They had a basic understanding but this was limited. The provider and previous registered manager had made several DoLS applications which were in place when we inspected. Although the DoLS were in place staff had not consistently followed the conditions of the DoLS approval. One person as part of their DoLS conditions should have had an electronic mat outside of their room to alert staff when they left their room. Instead staff had used a bed rail on the bed, which stopped them getting out of bed. This was not part of the DoLS conditions.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and

Inadequate

# Is the service effective?

Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not have suitable arrangements in place for obtaining consent of people in regard to their care and treatment.

Belgravia was registered to support people living with dementia, older people and people with learning disabilities. However they did not use any national good practice guidance for people living with dementia or people with learning disabilities. Neither did they have links with relevant organisations. There were no measures to improve well-being and independence for people living with dementia, such as contrasting coloured equipment, crockery and furnishings.

The environment was not designed to effectively support people living with dementia. It did not take into account the needs of people living with dementia with decoration, signage and adaptations. While there was signage for the dining and sitting room, many doors around the home had little to distinguish one from another, so people did not know which rooms were which. The signage with the names of the upstairs corridors was incomplete. Letters had been lost from the names making them illegible. This lack of dementia friendly surroundings made it difficult for people to orientate themselves around the home or to retain their independence.

**We recommend that the registered provider refers to guidance and best practice, in relation to the specialist needs of people living with dementia and people with learning disabilities.**

Requires Improvement

# Is the service caring?

## Our findings

People we spoke with told us that staff were kind and caring. They told us they were happy and satisfied with life in the home. One person told us "The staff are all good. They look after me." However our observation showed that care was not always satisfactory. People were not always getting care that met their assessed needs.

We asked people about their move to Belgravia care. A relative said that they did not choose Belgravia care home, "We had to use Belgravia Care Home. The social worker did not give us any choice." They told us they were not happy with the care provided for their family member, but they did not know how to change this.

We spent time observing care in all communal areas of the home. This helped us to observe the daily routines and gain an insight into how people's care and support was managed. Although the inspection found some good care we also found areas of concern. The inspection team observed care in a lounge for most of the day from 7am – 7pm. We saw that interactions although kind and caring were fleeting and infrequent. We observed people were left unsupervised by staff on a number of occasions. There were periods during the afternoon when there were no staff in the lounge when vulnerable people were there.

One person was taken into the lounge in a wheelchair and sat at a table by 9 am. This person remained there until we left the home at 7pm. There was very little interaction by staff other than to provide meals. The person had little to do at the table and was not given the opportunity of relaxing in an armchair. We were told this person was not able to remain in their bedroom as they were a risk if they stayed there. Other options were not sought and this information was not recorded in their care records.

Concerns had been raised with CQC about how little they felt people were showered. We looked at care records to see when people had showers. Showers were recorded infrequently. Staff told us that people were showered but they did not always record these. People were clean and groomed during the inspection but some relatives had concerns that this was not always the case. A relative told us that their family member was not always as clean as they would like. They said, "Sometimes she needs a bath."

Some people had en-suite showers but not all of them were suitable for them to use because of their physical disabilities. There was also a communal shower. When we walked around the home we saw there was a bathroom with a bath. However the room and the bath were used for storing equipment and not in use. This meant people did not have the option of having a bath rather than a shower.

We had also received concerns regarding the care of one person and the poor state of hygiene in their bedroom. When we looked around the home we saw that this person was laid in their bed which was stained and dirty, as was their bedroom. They had clearly been there for some time and staff had not attended to their needs. This meant they were not receiving good care.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not taken proper steps to ensure people's care and welfare was met.

We spoke with the manager about how they developed care plans when people were admitted to the home. Staff told us care plans and risk assessments were completed soon after admission. People or their relatives had been involved in providing information about people when developing the care plans. However there was no evidence that this continued when plans were being updated. One person told us, "I have no idea what will happen next for me, not a clue. No I don't know about my care plan." Another person said, "The social worker came to see me the day after I moved in here and I have not heard from her or seen her since then." A relative said of their family member, "No one is talking to me about their future care." This meant that people did not feel in control of their lives, or if appropriate part of their family members lives.

Staff said they worked with Independent Mental Capacity Advocacy (IMCA) and advocates where people lacked capacity. We saw from DoLS applications that this occurred. One member of staff said, "We have best interests meetings where needed and involve IMCA's." However some people we spoke with were not aware of advocacy services. One person said, "I have never heard of an 'advocate'. No I have not seen a social worker for a long time. I haven't had any meetings here to talk about me – my life – what I want."

Choices of when to receive personal care and support were limited by the staff routines. These were task centred rather

Requires Improvement

# Is the service caring?

than in response to people's individual needs and preferences and care was not person centred. Where staff were in the lounge they were not often involved in interacting with people. They were focussed on tasks that they needed to complete. There had been a high turnover of staff so staff were still getting to know people's needs and this limited their ability to provide individualised care. Person centred care aims to see the person as an individual. It considers the whole person, taking into account each individual's unique qualities, abilities, interests, preferences and needs.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not have suitable arrangements in place to enable people to participate in and make decisions about their care and treatment.

We saw some good interactions. Staff were aware of people's individual needs around privacy and dignity.

When they interacted with people they spoke with people in a respectful way. A relative said of their family member, "She is always treated with dignity and respect at all times." Staff knocked on bedroom and bathroom doors to check if they could enter. People felt they could trust staff and they were friendly and respectful. One person became distressed. A staff member calmed them down in a respectful manner. When the person was calmer, the staff asked them to come to the office to talk. The person showed some concern and said, "I'm not in trouble am I?" The staff reassured her that she was not in trouble.

We had responses from external agencies including the social services contracts and commissioning team and local authority social workers. Comments received from other professionals informed us that they had monitored the home regularly because of concerns about the home. They felt there was still much room for improvement. These responses helped us to gain a balanced overview of what people experienced living at Belgravia Care.

Inadequate

# Is the service responsive?

## Our findings

Staff told us that there were social and leisure activities provided frequently. However we saw little evidence of these during the inspection. Although we saw one member of staff involved in discussions with a small group of people, there was little activity for others. A member of staff showed us some activities that people could be involved in but these were limited. There were no activities specifically aimed at people living with dementia and they spent a lot of time unstimulated and unoccupied.

People told us that they had few social or leisure activities. One person said, "I get up around 8 or 9 am – have breakfast in the lounge – then sit doing my knitting in the lounge until dinner time and I stay in the lounge doing my knitting until tea. After tea I watch TV – sometimes in the lounge and sometimes in my room – that's every day since I came here. I have been out once – that was with my family, since I came here." Unless going out with family and friends or able to go out alone, people rarely accessed the local community. People told us that they did not get out very often. One person told us, "I don't get out now unless [My family member] takes me." We looked through records and talked with people, relatives and staff. It was clear that people had little opportunity to go out into the local community due to staffing and the support needs of others.

We looked at five peoples care records and other associated documentation. We looked at the care plan of one person who was in the home on a short stay. There was little information about the person's care needs. There were brief personal and contact details. There was also a tick box type of assessment that showed low, moderate or high needs in each area of care and brief generalised information about care. This made it difficult for staff to provide personalised care or to respond to this person's care needs.

Of the five care plans we saw, two were informative and could assist staff with information so they could provide the right care and support for people. The others had significant pieces of information missing. Although one person's file was informative and person centred, showing staff the care the person needed, it had not been updated in some areas. Information regarding staffing support and changes in arrangements for seeing their family were out of date. Four of the care records had care plans and risk assessments. Although some parts of the care plans were personalised, others were generic with the same statements in all files checked.

Care plan records for one person showed under mental capacity that they had mental capacity and that carers should take account of their wishes in any decision making process. However the DoLS record showed them not to have capacity. It was not clear which was correct. This meant staff did not have the knowledge they needed to provide person centred care for people.

The care files we saw had little evidence of people's preferences and personal histories. Where personal histories were present, these were given as timelines of events without any real feel of the person. The care records were computer based. They were laid out in such a way that it was easy to locate information.

Staff had completed Malnutrition Universal Screening Tool (MUST) with action plans and weight charts. However other assessments were not informative. Assessments for pain had either people assessed as having a score of zero (no pain) without an explanation of how the score was achieved or no assessment in place. There was no evidence of how the information to support assessments of pain was obtained from people who may have no verbal communication or language to describe pain or distress.

The care records showed statements regarding monitoring health needs such as 'monitor diarrhoea'. However there was no record of the actions being monitored. When asked "how do you monitor the actions?" The staff said "We don't at the moment but we are aware and are developing ways to do this".

We saw that although 'End of Life Care' was included in care plans this information was limited to funeral arrangements and not to the care and support people wanted as they neared the end of life. There was no evidence of Advance decisions to refuse treatment (ADRT's) in place or of people being given the opportunity, where appropriate, of discussing preferences and wishes for their future care.

This is a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and

Inadequate

# Is the service responsive?

Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not have suitable arrangements in place for recording information about people's care and treatment.

We were contacted prior to the inspection by professionals who were involved with people where moves to other services had been planned. The concerns included health, social services professionals and other service providers about the unwillingness of the registered provider and previous management team to share information when people were moving elsewhere. This put people at risk as the staff in their new homes did not have all the information they needed. Other professionals also expressed concerns that the registered provider and previous registered manager had strongly discouraged and disrupted planned moves for two people who had since moved elsewhere.

This is a breach of regulation 24 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not work in cooperation with others and share information when people were transferring between services.

We asked people if any complaints were dealt with quickly and appropriately. People told us they had no complaints about the home and were happy there. They told us they were aware of how to make a complaint and knew these would be listened to and acted upon. The home had a complaints procedure which was made available to people they supported and their relatives.

We spoke with the manager who told us that there had been no complaints raised since the manager had started working at the home in January 2015. There had been several concerns raised with CQC about care practice and levels of staffing in the home. Two people told us that they had raised this with the previous manager. However there were no complaints in the complaints file. The manager told us she and the staff team were available to speak with people and their relatives. She said any ideas would be considered and issues would be dealt with.

Concerns had been raised about staff getting people living with dementia up early in the morning before the night staff went off shift. When we gained access to Belgravia care at 6.45 AM four people were up and dressed in the lounge. Staff told us that they had chosen to get up and that people could choose when to get up and when to go to bed. We saw there was flexibility for people to choose when they wanted to have their breakfast.

Staff were welcoming to people's friends and relatives. They told us that there were no restrictions on visiting. One relative said, "I visit a lot. I have always felt welcomed and encouraged. I have never had to wait a long time at the front door."

Requires Improvement

# Is the service well-led?

## Our findings

There had been a change of manager since the last inspection. The registered manager had resigned in December 2014. 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.

A large part of the staff team had changed since the last inspection in September 2014. This reduced staff knowledge about the needs of individuals. A new manager had commenced in post in January 2015. She was starting the process of applying to become the registered manager with CQC. Staff that were recently recruited were enthusiastic about the improvements the new manager was making in the home but acknowledged that the changes were taking time to carry out. People told us the new manager was approachable and willing to listen to people. One person said, "She is nice." Relatives were also complimentary. A relative said, "I was worried about lack of staff and did feel that I could speak to the manager – I did feel listened to."

Staff felt supported by the new manager and motivated by her leadership. One member of staff told us, "There have been lots of changes and we need to get used to a new routine. But it has been for the best and I know we have a long way to go but things are getting better." Another member of staff said, "The manager is making good changes and improving the home."

The home was registered with CQC to support people with learning disabilities, older people and people living with dementia. However we saw that one person who was living at Belgravia whose presenting needs were of mental health. Despite this the registered provider had admitted this person to the home. There was no rationale of why the management team had admitted a person who they were not registered to provide care for and unable to support appropriately. A relative told us, "I thought that Belgravia Court Care Home was for people with learning disability and dementia. People with other needs can be challenging and throw things around when in a bad mood – I am worried for [my family member]."

There were some quality assurance checks carried out to monitor the quality of the service. These included monitoring the home environment, care plan records, financial records, medication procedures and maintenance of the building. The provider audited the home at least monthly and followed up on some issues found in order to improve the service. Yet the audit systems were not picking up the areas of concern identified during this inspection process. The home had consistently breached regulations during this and previous inspections. Legal obligations, including conditions of registration from CQC, and those placed on them by Deprivation of Liberty Safeguards authorisations were not always understood or met.

This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not have suitable arrangements in place for assessing, and monitoring the quality of the service and acting upon their findings.

The manager told us the views of people who lived at the home were sought by a variety of methods. We saw surveys about the person's experience of living in the home and 'residents meetings' minutes. These gave people the opportunity to voice their opinions. However it was not clear if these were acted on or people informed about actions taken. There were regular staff meetings and manager meetings with the provider. This gave staff the opportunity to discuss care practice and any changes in the home.

This section is primarily information for the provider

# Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>The registered person had not taken proper steps to ensure that each person was protected against the risks of receiving unsafe or inappropriate care as they had not taken action to ensure the welfare and safety of service users.<br><br>We found that the registered person did not have suitable arrangements in place to enable people to participate in and make decisions about their care and treatment. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>We found that the registered person did not have suitable arrangements in place for obtaining consent of people in regard to their care and treatment. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>People were not protected against the risks associated with medicines because the registered person did not have appropriate arrangements in place to manage medicines.<br><br>People were at risk from poor infection control as the registered person did not operate appropriate infection control practices.<br><br>The registered person did not work in cooperation with others and share information when people were transferred between services. |

This section is primarily information for the provider

# Enforcement actions

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The registered person had not taken proper steps to protect people against the risks of abuse because risks were not always assessed or appropriate action taken to keep people safe. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs<br><br>The registered person had not taken proper steps to ensure that each person received appropriate support to eat and drink sufficient amounts of food for their needs. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>People were not protected against the risks associated with poor record keeping because the registered person did not have appropriate and accurate information about the care and treatment of each person.<br><br>The registered person did not have suitable arrangements in place for assessing, and monitoring the quality of the service and acting upon their findings. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>The registered person had not taken proper steps to ensure that there were sufficient numbers of suitably qualified, skilled and experienced persons employed and deployed for the purpose of carrying on the regulated activity. |

This section is primarily information for the provider

# Enforcement actions

The registered person had not made suitable arrangements to provide staff with appropriate training to assist them to support people effectively.