

Countrywide Belmont Limited

Belmont House Care Home

Inspection report

High Street
Starbeck
Harrogate
North Yorkshire
HG2 7LW






Date of inspection visit:
24 January 2017
25 January 2017

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

The inspection took place on 24 and 25 January 2017. The first day was unannounced.

We previously carried out an inspection in October 2015, where we found the registered provider was not meeting all the regulations we inspected. We found the registered provider did not have suitable arrangements in place for obtaining, and acting in accordance with the consent of people in relation to their care and treatment as required by the Mental Capacity Act 2005. We also found that the registered provider did not have suitable arrangements in place to ensure the deployment of staff protected people from the risk of harm. We told the registered provider they needed to take action. We received an action plan from the registered provider telling us what they were going to do to address the shortfalls.

During this inspection we found that the assurances from the registered provider had been implemented with the necessary improvements being made across the service. However, we found shortfalls relating to the safe management of medicines. We also identified failings in the quality monitoring systems.

Belmont House provides residential, nursing and personal care for up to 106 people. The home is divided into five separate suites, spread over three floors. The Courtyard suite provides residential care for up to 30 people. The Garden and Springwater suites both provide nursing care for 14 people each. The Park suite provides residential care for up to 17 people who are living with dementia. The Promenade suite also provides care for 26 people who may be living with dementia, but also need nursing care.

The service had a registered manager. 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.

Overall people told us they felt safe. Staff understood how to safeguard people from abuse. We saw from the rotas that staffing levels were based on the registered provider's assessment of people's needs. However we recommended that the registered provider review their staffing levels more frequently to make sure there were no gaps in staffing provision. The recruitment process was robust and staff completed an induction when they started work. This reduced the risk of unsuitable people being employed. People were supported and cared for by skilled, well trained staff who took pride in their work.

We found that people were encouraged to exercise choice and control in all aspects of their lives wherever possible. Key people were involved in most of the best interests meetings for people who required additional support with decision making.

Any risks around peoples care were identified. Where risks were identified action was taken to minimise these whilst protecting individual's rights and freedoms.

People had food and drink to meet their needs. People were supported to receive their medicines as prescribed and to access their health care appointments to make sure they received appropriate care and treatment.

We observed good relationships were present between people who used the service and staff. Staff were knowledgeable about the people they supported. This was confirmed in feedback we received about the service. During the whole inspection we noted multiple examples of good practice, excellent care delivery and an atmosphere of caring, compassion and a relaxed environment.

People had comprehensive care and support plans in place. However, the level of detail varied across the service. The information guided staff on people's preferred approach to meet their care needs. An example of this was how one person liked to have their clothes protected whilst eating at the table.

A complaints procedure was in place. People confirmed they knew who to speak to if they had any worries or if they were unhappy about something. People told us they had not raised a complaint but said they knew how to if they needed to. People told us they thought they would be listened to if they raised an issue. They said the registered manager and the registered provider would act upon any concerns raised with them.

The registered provider undertook a range of audits to check on the quality of care provided. However, these were not always effective at highlighting issues which needed attention. People were asked for their views and their comments were used to identify improvements.

We found two breaches in regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the registered provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

Arrangements were not in place to ensure that medicines were administered safely and in accordance with the person's healthcare needs. We could not conclude that people received their medicines safely.

Management processes and systems promoted people's safety and welfare. The registered manager knew about local safeguarding protocols and staff were trained in the use of these.

Robust recruitment checks were followed before new staff began work.

Staffing arrangements were suitable to meet the needs of people who used the service. However we recommended that the registered provider review their staffing levels more frequently to make sure there were no gaps in staffing provision.

Is the service effective?

Good ●

The service was effective in meeting people's needs.

Staff were trained to meet people's needs, choices and preferences. They were knowledgeable about individual's care and support needs.

People's rights were protected because the registered provider involved them, or their relatives, in decisions made about their care. Where people could not consent, best interests meetings were held to ensure their view was taken into account.

People received food and drink to meet their needs.

People were supported to access health care to make sure their care and treatment needs were met.

Is the service caring?

Good ●

The service was caring.

People spoke positively about staff and told us they were friendly and patient. People's independence was promoted

People's rights to privacy and dignity were respected. We saw during our inspection that positive relationships existed between people who used the service and staff. This was also confirmed to us when we spoke with people.

Is the service responsive?

Good ●

The service was responsive.

People's care and support needs were regularly assessed. Care and support plans were kept under review and updated, to meet people's changing care needs and circumstances.

People had access to in house entertainment and staff knew how best to keep people occupied and stimulated.

People knew who to speak to if they were worried or unhappy about something. People were confident that action would be taken if they raised a complaint.

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

There was a registered manager. The registered manager and registered provider demonstrated an open, person centred culture.

Effective management systems promoted people's safety and wellbeing.

The registered provider undertook a range of audits to check on the quality of care provided. However, these were not always effective at highlighting issues which needed attention.

Belmont House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 24 and 25 January 2017 and was unannounced. On day one of the inspection the inspection team consisted of two adult social care inspectors and an inspection manager. Two specialist advisors also assisted with the inspection on day one. On day two of the inspection the inspection team consisted of two adult social care inspectors.

At the time of this inspection there were 86 people living at the service. During the inspection we spoke with 23 people who used the service. Although there were relatives visiting the service during our inspection. We did not have the opportunity to speak with them. However, we left leaflets and inspector contact details for the registered manager to hand out to allow people the opportunity to share their views about the care being provided. At the time of writing this report, no one had contacted us.

We also met and spoke with the registered manager, deputy manager, quality assurance manager, a regional director, eight care assistants, a senior care assistant, two activity organisers, four unit managers, a housekeeper, a chef, a maintenance worker, three health care professionals (visiting) and two visitors. We spent some time looking at documents and records that related to people's care and support and the management of the service.

Before the inspection, the registered provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information when planning for the inspection visit. We also reviewed all the information we held about the service and contacted the local authority who funds some of the care provided. The local fire authority had told the provider to make improvements in the service in 2016, so we contacted the fire officer for more information.

We reviewed a sample of records relating to the management of the service such as the quality assurance,

recruitment and staff training. We also checked the fire and electrical maintenance documents and infection control audits. We reviewed six staff files, 15 care plans and a random selection of medicine records.

Some people who lived at the service had complex needs and were not able to verbally communicate their views and experiences to us. Due to this we used a formal way to observe people during this inspection. We 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.

Is the service safe?

Our findings

People told us they felt safe overall and that staff were committed to their work. Comments included, "I feel safe. The staff are very caring." And, "Nowhere is perfect but it's very near." One person told us that staff lacked an in depth knowledge of their specific condition but overall they were satisfied with the service.

At the last inspection we rated this domain as requires improvement. We concluded at that time that the registered provider had not taken appropriate steps to make sure staff were deployed in order to fully meet people's needs. This meant that during that inspection people who used the service were left unsupervised and at potential risks of falls. The inspectors present during that inspection had to intervene and alert a member of staff. Following our inspection the registered provider sent us an action plan setting out the steps to be taken to address this shortfall.

At this inspection we found that staffing levels were appropriate. Senior staff were mindful that they needed to constantly oversee areas where people required two members of staff to provide personal care. In these situations a member of staff had to be deployed to supervise communal areas, where people required constant supervision.

We saw from the rotas that staffing levels were based on the registered provider's assessment of people's needs and that formalised calculations were submitted to the directors on a bi monthly basis. We recommended that the registered provider review their staffing levels more frequently to make sure there were no gaps in staffing provision. We received differing views from staff about staffing numbers. One member of staff told us, "It looks on the face of it as though we have enough staff but in reality we don't." They explained how when they were busy keeping people safe and well, that the paperwork was left as they thought care was their priority. This was a common theme when speaking to staff. Despite this, it was evident that where needed additional staff had been provided to cover situations such as an acute deterioration in people's individual conditions or where an identified need was highlighted. This included both day time and night time staffing numbers. On two of the units staff told us that most people required two staff to support them and that a third member of staff was present in the communal areas. This was so that they could be available should anyone require attention. Staff told us they could call on staff from other areas of the service, if they needed additional support. However, due to the complex needs of some people an 'unfamiliar face' could cause people to exhibit more distressed behaviour. Staff told us they considered the dynamics of the group and their needs continually to make sure they were aware of any changes in behaviours so that they could adapt their approaches and support accordingly.

Staff vacancies were being covered by agency staff. The registered manager confirmed that the same agency staff were being used regularly and this meant they had got to know people who used the service and the permanent staff team. The registered manager kept a profile of each agency worker including a photograph, training received and other employment checks. We discussed the need for staff overseeing each of the units to have access to this information also. This would allow for them to correctly identify who was reporting for duty and provide assurances that people were being supported by the correct agency staff. On call arrangements were organised well and staff told us they knew who to call if they needed advice at any

time, including during the evening and night.

It was anticipated that the use of agency staff would be significantly reduced following the recruitment of new staff, including a nurse and ten care assistants.

We reviewed the recruitment processes and found there was a robust recruitment system in place. All the required checks were completed before staff started their induction process and worked with people unsupervised. Pre-employment checks included references and checks with the Disclosure and Barring Service (DBS). This check helps employers make safer recruitment decisions and prevents unsuitable people being employed. People were supported and cared for by skilled, well trained staff who took a pride in their work.

There was a system in place to log and investigate safeguarding concerns, should they arise. The registered manager understood their role and responsibilities with regard to safeguarding and their responsibility to submit statutory notifications to CQC. One safeguarding matter was discovered during routine discussions with people who used the service. This was immediately brought to the attention of the registered manager, the quality assurance manager and the regional director. Immediate action was taken by the home manager and safeguards put in place pending the outcome of an internal investigation and referral to the local authority safeguarding team.

Staff told us they would report any concerns to a senior member of staff, the registered manager or the registered provider if they suspected abuse or had concerns about the people who used the service or any of the staff.

People who used the service or their relatives were involved in the planning of individual care and treatment in relation to the management of risks as much as possible. Assessments were used to identify any risks to the person who used the service, whilst minimising any restrictions placed upon them. These included, for example, any risks due to the health and support needs of the person such as walking, falls and pressure ulcer prevention. Risk assessments also included information about when people might become anxious or distressed and guidance on the correct staff approach on these occasions to help calm the situation and reduce the distress. We found that people were encouraged to exercise choice and control in all aspects of their lives wherever possible. Key people were involved in most of the best interests meetings for people who required additional support with decision making.

We noted that the fire safety risk assessment had been completed in March 2016, action had been taken to mitigate risk and the fire system is designed to create an automatic and direct alarm to the fire service. However, it was of concern that not all staff had been involved or participated in a fire drill in the last twelve months. Once alerted to this on the first day of the inspection the quality assurance manager arranged for all staff to have a fire drill before 27 January 2017 and to consult with the fire officer for agreement about the frequency of future fire drills.

There were robust systems in place to ensure the service was kept clean and well maintained.

We saw people had a personal emergency evacuation plan (PEEP) in their files. PEEPS were kept to ensure guidance was available if the service needed to be evacuated in an emergency. The PEEPS took into account people's mobility, understanding and care needs.

Staff were aware of the reporting process for any accidents or incidents so that appropriate action could be taken. Appropriate systems were in place to audit incidents and accidents to ensure action was taken to

help protect people. The registered manager told us they analysed this information for any trends and themes so that action could be taken to reduce the likelihood of them recurring.

We found staff safeguarded people from experiencing any discrimination or unequal treatment, which could result in their needs not being recognised or met. External agencies were involved as appropriate to give staff any additional guidance about people's care needs and additional support they might require. Examples included the involvement of district nurses where people needed dressings or support with continence needs.

We looked at the arrangements for the management and storage of medicines. Medicines records were electronic and the system had a monitoring and alerting system built in. This helped to minimise errors occurring. For example, the computer would alert staff if someone had missed a dose of prescribed medicine or when to remove or reapply a pain relieving patch. Staff told us the system worked well and there had been no medicine errors since the system had been introduced.

Storage arrangements were appropriate. Clinical rooms were found to be clean and stock control was well managed. However, not all clinical rooms were being maintained at an optimum temperature (below 25 degrees Celsius) which could have an adverse effect on medicines if they are exposed to high temperatures over a prolonged period of time. Attempts had been made by the registered provider to provide air conditioning in these rooms but this had not worked effectively. Staff told us this was a problem particularly in the warmer weather.

Controlled drugs (medicines that require special management because of the risk they can be misused) were stored in separate locked cabinets. The controlled drugs register had been signed by two members of staff. The drugs being stored balanced with the registers we looked at.

We asked staff about medicines which were given 'as required' and homely remedies. Staff were not clear about the protocols in place and there was scant information recorded in the medicines records to direct staff when and how much medicine should be used. We were subsequently told by the registered manager that there were PRN protocols in place. However, these were not available at the time of the inspection and staff were unable to provide us with examples. Staff were not being given sufficient guidance about the use of these medicines. Services need to produce their own guidelines and procedures around this type of medicines administration. This practice was also contrary to the services own medication policy which stated, "All PRN/variable dose medication must be accompanied by a written protocol, which must be kept with the residents MAR." (A MAR is a medication administration record.) And, for homely remedies, "It is very important to understand that these medications may interact with medication that individuals are prescribed by their doctor. Therefore, the GP's advice and approval must be sought and obtained before any household remedies are administered to individual service users." We found one example where a person who used the service was using throat pastilles and indigestion remedies which had not been prescribed. There was no information in the care records detailing any counter indications with other medicines. This was contrary to the services own medication policy.

Where emergency rescue medication was being used, for example, where a person suffered from a condition which made them prone to fits, the emergency protocols to be used were not adequately recorded.

Where people received their medicines covertly, for example, the medicine was disguised in food or a fluid to aid administration. We could not be sure that consent had been given or that best interest procedures had been followed correctly. In some examples we saw that the pharmacist or doctor had been consulted but there was no clear evidence of who had made the decision and if the right principles of the Mental

Capacity Act 2005 had been followed where people lacked the capacity to consent.

Where prescribed creams and lotions were being administered the electronic recording system did not record this. Staff working with the person and applying the creams were responsible for completing a paper record. We found and staff on the units confirmed that these were not up to date. The system in use did not provide accurate information about the administrations of creams.

These shortfalls meant that arrangements were not in place to ensure that medicines were administered safely and in accordance with the person's healthcare needs. We could not conclude that people received their medicines safely.

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

We noted some good practice with the physical administration of medicines. People were asked to take their medicines in a calm manner; the staff explained what the medicines were for and provided water for people. They also stayed until all the medicines were taken. For one person the medicine had changed and the staff explained the changes to them. In another example, we observed someone self-administer their prescribed medication. They told us how this was organised and managed by staff and that they felt able to continue self-medicating whilst receiving the correct level of support.

Is the service effective?

Our findings

People were positive about the knowledge and skills of the staff. Comments from people included, "Staff are really good. I am treated very well here." And, "I get everything I need, if I need help I call the staff using my alarm and they come really quickly." Another person told us they were happy with the care; that all staff were friendly, caring and approachable.

The service employed maintenance personnel and a maintenance contractor was used where necessary. Staff told us maintenance issues were dealt with promptly by the registered provider. Servicing and maintenance certificates were in place. Systems were in place to ensure a safe environment for people. These included for example, regular health and safety environmental checks on hoists, wheelchairs and fire safety equipment.

We saw reminiscence and tactile objects along corridors to provide stimulation for people. However, the service could further enhance and improve the units accommodating people living with dementia. For example, improved signage, clocks and dates to orientate to time and place, colour contrasting for floor coverings and bannisters. There was also a lack of storage in people's ensuite facilities. Despite this, the service had a homely feel throughout and was clean, fresh smelling and hygienic. Throughout the inspection we saw staff engaging with people on a one to one basis discussing areas of interest and making sure they had all they needed and were comfortable. Efforts had been made to get to know people and what they enjoyed to do or did before moving into the service. This information was then used to engage people and help them participate in things which were important to them.

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. The application procedures for this in care homes and hospitals are 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 authorisations to deprive a person of their liberty were being met.

At the last inspection we rated this domain as requires improvement. We concluded the registered provider did not have suitable arrangements in place for obtaining, and acting in accordance with the consent of people in relation to their care and treatment as required by the Mental Capacity Act 2005. The registered provider had not properly supported people to make decisions in circumstances where they lacked capacity and applications had not been made to the correct authority where people were deprived of their liberty. Following our inspection the registered provider sent us an action plan setting out the steps to be taken to address this shortfall.

We found at this inspection that some improvements had been made with regard to this. Further work was

being done to make sure correct procedures were being consistently followed on each of the units. We saw the action plan in place and who was responsible for each of the actions. One issue which was being addressed by staff was that best interest and MCA documentation was being completed using an electronic system. Once a meeting was held or decision made it was not possible for those involved to sign the documentation. We found the service recognised a link between risk and when a best interest decision needed to be made. However, best interest processes did not always involve people who were independent of the service. Paperwork was in place but without the involvement of key people the best interest decision making process was only partly adhered to. We noted that the registered provider had taken steps to improve this and seek advice from others where necessary.

Staff had access to a policy outlining the principles of the MCA and how people should be supported with decision-making. Staff had a general understanding of MCA. We observed staff routinely sought consent and offered people explanations before support was provided. This was done in a discrete and helpful way. We saw staff got down to the person's eye level and made sure they understood what was being asked of them. Staff had had a clear understanding of what MCA meant in practice and the impact it had on people who lived at the service. An independent advocacy service and independent mental capacity advisors visited the service and were used to provide further support for staff. There were 14 DoLS authorisations in place at the time of our visit and a number of applications had been made and were being processed. The registered provider had informed us of those approved.

Staff told us they received training to give them the skills they needed to meet people's needs, choices and preferences. Training included both face to face sessions and computer based learning. Staff told us that they were encouraged to put forward ideas for training opportunities and these were supported. Recent training had included, first aid, infection control, dementia awareness, breakaway techniques and moving and handling. 42 staff had a national vocational qualification ranging from level 2 to level 5.

Staff confirmed they received regular supervision to enhance their skills and learning and this was confirmed in the records we reviewed. They said that they were well-supported to fulfil their roles by both the registered manager and other senior staff in the organisation. Nurses received clinical supervision and support and this was linked to their own learning objectives.

One member of staff told us, "I love working here." They went on to say they would be happy to have a relative of their own family admitted for care. Staff told us they worked as a team with a shared commitment to provide a good quality of life for people at the service. Another member of staff told us, "We know people, but it is a high demanding unit and the work doesn't suit everyone."

We checked how the service met people's nutritional needs. The majority of people told us the food was well presented and that they had variety. One person told us, "The garlic bread was nice today, cooked just right so it was not hard." Another person told us, "We have a special menu for tomorrow for Burn's night." Two people told us the food was not always what they liked and one person wanted a different choice of vegetables.

People's care records included nutrition care plans and identified actions such as the need for a modified diet. People required different levels of support and we saw this was recorded in their care records. When we spoke with the chef it was clear that they knew what diet everyone needed and was able to describe to us how they made sure people who were at risk of losing weight for example, were given fortified foods and high calorific dishes. Up to date and accurate information was provided to the kitchen daily and any changes to a person's diet or choices were communicated to the kitchen so that people's preferences were met. For people who required a liquidised or soft diet, efforts were made to make the food still look

attractive and individual servings were pureed. For example, a meal included separate portions of vegetable, potato and meat so that the person could experience the different flavours.

At the time of our visit a four weekly rotating winter menu was in place. The home had received 'Gold Award for Health Care Choices' which is a business award scheme which recognised businesses in North Yorkshire that provided their customers with healthier eating options.

Some people required minimal support with their nutritional requirements whereas others required full assistance with all their meals and drinks, to ensure their safety. We saw that speech and language therapists (SALT) had been consulted to provide individual guidance and support as required.

We observed breakfast and lunchtime meals on some of the units. Food was home cooked and staff sat down with people to offer discrete support and encouragement appropriately. People were given ample time to enjoy each dish before extra helpings were offered or their plate was removed. Mealtimes were a relaxed social occasion and people clearly enjoyed the food and the opportunity to 'chat' with each other.

People were weighed on a regular basis according to their needs; this usually meant a weekly or monthly check by the staff which was then recorded in their care file. The care staff monitored their weight gain or losses and liaised with the doctor and dietician as needed. All visits and outcomes were recorded in the care files. We saw that input from these specialists was used to develop the person's care plans and any changes to care were updated immediately. This meant people's health and wellbeing was monitored so they remained well and received appropriate care and support.

We observed two handover sessions at the beginning of the inspection on day one. The information shared was comprehensive and gave staff working on the unit an up to date report of each person. For example, staff were told who was up and at what stage they were with their breakfast and if people required specific support around their levels of anxiety. Staff were also told what their individual responsibilities and roles were for the morning shift.

Is the service caring?

Our findings

People spoke in positive terms about the staff. Peoples' comments included, "It's hard for them, and some of them need a lot doing for them. I am impressed by the way they deal with people, never shout or sharp. They have endless patience." And, "The girls are wonderful. I need nothing more than I have here." And, "We need love and attention and we get that. I feel special, they take their time to make sure I have everything." People talked about the care and attention they consistently received from staff. One person, who had not been in the service long told us, "I have really settled. There is no reason not to stay. They are good to me and I enjoy it."

People looked comfortable in their surroundings. People were at ease with the staff who supported them. Staff intervened to help if people needed attention. We saw staff being patient and gently reassuring people as required. We gained the impression that staff knew people very well and how best to support them. We saw a variety of ways being used to promote peoples independence and maintain their dignity.

Staff developed ways which helped people maintain their independence. Where they could they reintroduced tasks and hobbies so that people could keep themselves occupied in a meaningful way. This included engagement with domestic chores or activities within the service and community where appropriate.

When staff were talking about people it was in a caring way. They used language which showed they had concern for people and they discussed amongst themselves what a person's behaviour or demeanour may mean so they could intervene appropriately. For example the night nurse handed over, "a person was restless and we checked if they needed the toilet, offered a drink and some food before we offered pain relief".

People looked well cared for and staff had taken time to ensure people were smart. This included grooming, hair styling, jewellery and nail care.

Rooms were very personalised, including memories of people's families or cherished items they had brought with them, including furniture. One person had an assisted hearing device which staff were seen to use appropriately to ensure they could hear what the conversation was.

We found positive relationships existed between staff and people who used the service. This was confirmed from our observations of people's interactions with each other and with the staff. Care being provided was person centred and focused on maintaining people's independence. We observed staff were compassionate and attentive.

We observed staff respected people's privacy. Staff were observed knocking on people's bedroom doors before entering. We were told people were encouraged to maintain control in their day to day living. This, staff said, was possible because they were caring for relatively small groups of people on each of the units, so they could adapt to meet everyone's needs and make allowances for each eventuality. For example, on

one of the units 'tea rounds' had been stopped. This meant that anyone needing a drink was provided with it on request or when needed and so reduced institutional practices.

Where personal care was needed, people were assisted to either their bedroom or the bathroom. This meant that care needs could be dealt with in private.

Care plans included information about a person's lifestyle, including their hobbies and interests, and the people who were important to them. This showed that people and their relatives had been involved in assessments and plans of care. Staff told us that they kept up to date with people's changing needs through handovers at the start of each shift and reading the care plans.

Is the service responsive?

Our findings

Records showed that people's care needs were assessed before they moved to the service. Other significant people, such as relatives, were also consulted where necessary to gather additional information. The registered provider's service user guide sets out people's access to records and their rights, including people being able to make choices relating to their care delivery. Also, the right to be consulted about daily living arrangements and to participate in discussions about any proposed changes to these arrangements.

This ensured staff had as much information as possible about each person to help them decide if they could meet the person's needs.

The level of information and detail in care plans differed between each of the units. Some care plans provided a good level of detail and others less so. Where care plans lacked specific detail it was clear that people were receiving the necessary support and treatment but this was due to the staff knowing the person well and not the detail in the care plan. This was discussed with the registered manager and quality assurance manager during the inspection who agreed that some care plans lacked detail and this had been picked up during the quality assurance managers monthly visit. Work was being done to make sure all care plans were of a good standard and included all the required details.

Staff were knowledgeable about the people they supported and knew about people's life choices and care preferences. This enabled them to provide a more person-centred service. Staff knew how best to respond to people who had limited understanding. Examples of this were seen during our inspection. One person was displaying anxiety and staff immediately asked for the area to be cleared so the person's anxiety did not escalate. Staff knew this was a trigger. The person received one to one attention and the staff member gently calmed the person, and the intervention worked. Another example was, a person was observed being verbally aggressive to a member of staff. The member of staff responded calmly and distanced themselves to ensure the person had space and privacy, without them leaving the area. The same staff member then naturally re-engaged with the person and the person responded in a positive way. This displayed professionalism and also let the person know they cared. This was a good example of positive behavioural support.

We saw that records included information about people's health and dietary requirements, together with their likes, dislikes and preferred lifestyles. This information was used to develop their care plan, which specified clearly how these needs were to be met. For example, with regard to mobility, personal care and meals provision. For one person their care plan stated they did not like big group activities. It stated, "I like interaction with others in the form of friendliness and polite conversation." This helped staff provide care in a way that met the person's preferences. Another care plan stated, "Enjoys gardening but is unable to do so and to compensate likes to keep plants and flowers in their room." There was evidence of community involvement such as the 'library ladies' who collected and distributed books and regular visits from a local school on the same site. People also completed college courses and attended a local sports facility.

Some people who lived at the service had variable concentration spans. Staff found that if they engaged

them in tasks they enjoyed, this could distract them and help them feel valued.

The service had taken the initiative for dementia awareness and created a Dementia Forum to create a better understanding of the effects on someone living with dementia. This is an example of good practice and development. Information was available in the entrance for people to access.

We saw a number of activities being offered during our two day inspection. We spoke with two of the three activity workers employed. They both spoke enthusiastically about their work. They told us, "We have started to work weekends in rotation to offer a better service." And, "Where people cannot access activities we try to bring activities to their room. For example we have a singer who visits and he will go into their room if they want and sing." On one of the units we saw a dominoes activity taking place. People were engaged and told us it was a dominoes club. They totted up the scores and at the end of the month a winner was announced. One person said "It keeps us happy and occupied." There was a wide range of external social events on offer, such as visiting the local library every alternate Tuesday and trips out to places of interest. During our visit we also saw a quiz session and bingo game being played. All activities were advertised and illustrated with pictures. Other activities advertised included seated exercises, entertainers, pet therapy and trips out. We were also told that the service had won the Gold Award for "Starbeck in Bloom" which had been an activity people had enjoyed participating in and were very proud of. Staff told us they took a "whole team approach" to activities.

One person writes a regular bulletin for the service called "Belmont House Through A Residents Eyes." The bulletin is distributed to each unit and copies were available in the reception area.

We looked at the arrangements in place to manage complaints and concerns that were raised. We noted four complaints in October 2016 which had been managed and investigated in a timely, sensitive and fair manner. One complaint in 2017 had also been dealt with in accordance with the registered provider's complaints procedure. We saw a number of thank you cards and comments from relatives detailing their appreciation of the service. None of the people we spoke with had had to raise a formal complaint. They told us that if they were unhappy about something, they raised it at the time and action was taken immediately. These had been minor matters and had not needed to be made formal.

Is the service well-led?

Our findings

At the last inspection we rated this domain as good. However, the lack of robust audit systems in place meant that the service was not being as well led as previously.

The registered provider and registered manager had an overall grasp of the running of the service. We saw records of audits, including checks made on equipment to make sure it was safely maintained and in good working order, for example call bells, mobile hoists, profiling beds and any bed safety rails in use. Other audits included medicines management, falls monitoring and analysis, care plan records and food provision. However, not all of them were effective in highlighting issues for action. For example, medicines management was not properly overseen and not everyone had participated in fire safety training, including fire drills. There were also inconsistencies in the levels of detail in care plans between each of the units. Some care plans contained more detail than others. Where care plans lacked specific detail it was clear that people were receiving the necessary support and treatment but this was due to the staff knowing the person well and not the detail in the care plan.

There were comprehensive records of in-house fire safety checks by the maintenance person, who also led on fire drill provision, but it was clear that there was a poor take up and that only a small number of staff took part. This poor level of fire drill training was of concern and this included both day and night staff. The audit for fire safety training was not robust and improvements to this were required.

We identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

The provider information return (PIR) also contained information that indicated the registered provider monitored and reviewed the quality of care and support provided. There were also long term plans to continually upgrade and improve the service. The registered provider had an annual maintenance plan which included upgrades and refurbishment.

The registered provider had systems in place to make sure a senior manager from the organisation visited the service at least once a month and looked at all aspects of the running of the service. A report was then created and agreed action points and timescales were added. There was also an annual quality report used in conjunction with this.

The registered provider had used an external organisation to carry out a resident's survey. However, the only results available to us during the inspection were from the survey undertaken in 2015. The area manager told us that a repeat survey was undertaken by in October 2016 but they were still waiting for the outcome and report. There were also systems in place to seek the views of relatives and people who used the service to make sure their ideas and suggestions were considered and acted upon where appropriate.

The poor take up at general staff meetings had been addressed by the use of 'unit meetings' across all five areas which were taking place on a regular monthly basis. We viewed the minutes of these meetings and

found that a range of topics were covered which were relevant and well recorded.

Staff told us they felt supported, and that they had plenty of opportunities to reflect on the service they provided through supervision and unit meetings. Staff we spoke with were enthusiastic about their work and understood their roles and responsibilities. We gained the view that the staff team were committed to the service. Staff told us they had a shared commitment to provide a homely and caring environment to people who lived at the service and that they valued the contribution they were making. We noted a lively and positive culture within the service. Staff morale was described as "good" and staff told us they got on well. Staff told us sometimes the home felt 'hectic and stressful' when there was a lot of activity and at peak times during the day but that they worked hard to contain this. They told us they approached this by prioritising what needed doing and inevitably things became calmer because they were competent at their jobs.

During our inspection the atmosphere throughout the home was welcoming and lively at times. This was initiated by staff and people who used the service. There were busy periods, for example during lunchtime, but staff were well-organised and worked efficiently without rushing people. We noted overall an open and supportive leadership atmosphere in the home.

The registered manager was aware of notification requirements. We had received notifications about appropriate events that occurred at the service. Notifications are incidents or events that the registered provider has a legal requirement to tell us about. This enables us to check what action the registered provider and registered manager have taken in response to them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|--|--|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | The provider did not have robust systems in place for the proper and safe management of medicines. |

| Regulated activity | Regulation |
|--|--|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The provider did not have systems and processes in place to assess, monitor and improve the quality and safety of the service. |