The Belmont Care Home Limited

Belmont Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 10 and 13 January 2017. After that inspection we received concerns in relation to how the home managed risks in relation to falls, pressure ulcers and medicines. The local authority also informed us they had suspended placements at the home because of their concerns. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Belmont Care Home on our website at www.cqc.org.uk

This inspection took place on 27 March 2017 and was unannounced. At our last inspection in January 2017 we rated the home 'Inadequate' and placed the service into special measures. The overall rating for this service remains 'Inadequate' and the service remains in special measures. We identified breaches of the regulations in relation to the safe management of medicines, assessing and taking action to reduce risks to people's health and wellbeing, good governance and staff support and supervision. We are currently considering our options in relation to enforcement and will update the section at the end of this report once any enforcement action has concluded. Due to concerns we identified during the inspection we also made a referral to the local safeguarding authority.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

Belmont Care Home provides residential care without nursing for up to 40 older people. The home is situated in Cheadle close to local shops and other amenities. Car parking is available to the front and side of the building. At the time of our inspection there were 33 people living at the home.

Prior to this inspection we were made aware of concerns in relation to how the service managed risks

relating to pressure ulcers. We found staff were aware of signs to look for that might indicate someone was developing a pressure ulcer, and further training was scheduled to further improve staff knowledge in this area. However, we found staff were not consistently following directions in people's care plans to reduce the risks of them developing a pressure ulcer.

The service assessed risks to people in relation to pressure ulcers and falls. However, risk assessments were not always re-visited following a change in a person's condition or circumstances, and risk management plans were not always up to date. This meant there was a risk that staff would not provide the support people required to keep them safe.

Staff told us there were sufficient numbers of staff on duty to allow them to complete their duties and supervise people who were at risk of falls. However, care plans were not clear about how frequently 'checks' should be completed.

Staff were aware of procedures to follow in the event that someone sustained a fall, and additional staff had received training in first aid since our last inspection. However, records in place to monitor people's falls and other accidents were not always completed. It was not always possible to tell what actions had been taken as a result of falls or other accidents.

All care staff were required to complete care plans and risk assessments. Some staff told us they were not confident in completing such tasks, and only limited support had been provided to staff to enable them to complete these tasks. The registered manager acknowledged that care plans and risk assessments were not always satisfactory.

There was a lack of any robust process to give the registered manager and provider an overview of the safety of the service. Staff told us accidents were not discussed with them, and there was no evidence that learning had taken place as a result of previous accidents and incidents.

Reasonable steps had not been taken to ensure the environment was safe for people living at the home. We found items including razors and cleaning products stored insecurely.

Medicines were left with some people to take without supervision. The registered manager was unable to demonstrate that potential risks to the person or others living at the home had been considered in relation to this practice.

There was a registered manager in post. 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.

Whilst staff spoke positively about the registered manager, they felt that due to demands of their time that there was limited support available to staff. The records did not demonstrate that all staff had received regular supervision, and those supervisions that did take place were conducted by a member of administrative staff. The registered manager told us they had recently recruited a second member of administrative staff, and were actively recruiting to the role of deputy manager, which they hoped would reduce demands on their time.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Staff did not always follow guidelines in people's care plans and risk assessments to reduce risks from pressure ulcers or falls.

Some people were left to take their medicines unsupervised and there had been no assessment to determine if this was safe practice.

We found adequate steps had not been taken to ensure the environment was safe. We observed items including razors, scissors and cleaning products were not stored safely.

Is the service well-led?

Inadequate

The service was not well-led.

There were no systems to monitor trends relating to accidents and incidents, and there had been no analysis of previous incidents.

Staff told us communication with them was poor. Not all staff had received adequate supervision and support.

Staff spoke positively about the registered manager, but felt their work-load was too large. A second member of administrative staff had been recruited to support the registered manager.

Belmont 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 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.

We undertook an unannounced focussed inspection of the Belmont Care Home on 27 March 2017. The inspection was prompted in part by two incidents that occurred at the service and resulted in those people sustaining serious injuries. This inspection did not examine the circumstances relating to these incidents, which are subject to on-going enquiries. We also received information of concern from a whistle-blower and via the local authority shortly after our last comprehensive inspection in January 2017. This information indicated potential concerns about the management of risk in relation to medicines, falls and pressure ulcers. This inspection examined those risks and the team inspected the service against two of the five questions we ask about services: is the service safe, and is the service well-led?

The inspection team consisted of one adult social care inspector and an adult social care inspection manager. Prior to the inspection we reviewed information we held about the service. This included previous inspection reports, information shared with us about the service via phone, email and the 'share your experience' web-form, and statutory notifications submitted to us by the service. Statutory notifications contain information about deaths, serious injuries and other significant events that the provider is required to send to us.

During the inspection we spoke with three people who lived at the Belmont Care Home, one visiting health professional and five members of staff. This included the registered manager and four members of care staff. We carried out observations of the care and support staff provided in the communal areas of the home. We looked at records relating to the care people were receiving, including four medication administration records (MARs), five care files and daily records of care. We also reviewed records related to the running of a care home, including records of staff supervisions and training.

Inadequate

Is the service safe?

Our findings

The service was not effectively managing risks, including those in relation to falls and pressure ulcers. Staff had completed risk assessments in relation to falls and risk of pressure ulcers. However, we found that where risks were identified, there were not always clear plans in place about how staff should manage these risks. In other instances we found risk management plans were not followed by staff, which placed people at risk of harm.

Shortly following our last inspection in January 2017 we were made aware of concerns relating to the way the service managed risks relating to pressure ulcers. Staff we spoke with were aware of signs to look for that might indicate a person's skin was starting to break down and would indicate further advice or intervention was required from a health professional such as a district nurse. The local authority had also supported the service to arrange training in pressure care for staff. We spoke with a district nurse who told us they found staff recognised signs of pressure ulcers developing, but said staff did not always inform them of any signs of deterioration as promptly as they would like. They told us whilst records of positional changes indicated people received support as required, they could also occasionally find people had not been positioned correctly as advised by the district nursing team.

One person's care documentation indicated they were at high risk of developing a pressure ulcer, and that staff should ensure they sat on a pressure relief cushion and applied cream to reduce the likelihood of a pressure ulcer developing. However, staff told us this person was not currently prescribed any cream medicines, and we found this person was not sat on a pressure relief cushion. This meant staff had not taken reasonable actions to reduce the risk of this person developing a pressure ulcer. In other care plans we saw directions about people's need for support to change position were unclear, which meant there was a risk staff would not provide people with pressure relief as required.

Staff we spoke with were aware of the home's procedures in relation to providing support to people following a fall. For example, staff told us they would press the emergency call bell, reassure the person and wait until a senior member of staff had assessed whether an ambulance was required. Staff told us they felt there were adequate numbers of staff available to allow them to regularly check on people who were at risk of falling, and they told us two staff were always required to be 'on the floor' to cover the communal areas. One person we spoke with told us; "There are staff around when you need them." However, people's care plans lacked clarity about how frequently these checks should be completed.

We saw evidence that staff had undertaken first aid training since our last inspection, which would help ensure staff were able to recognise any signs of injury and deliver emergency care if required. Staff told us they would observe people who had sustained a fall on a regular basis following and incident. However, we found records of such checks were not kept consistently. Post-incident observations are important to ensure staff recognise potential injuries, including head injuries that might not have been immediately apparent at the time of the accident.

We saw people's care files contained 'trackers', which were used to document any falls or accidents they

had sustained. However, these had not always been kept up to date, which meant it was difficult to determine if and when people had fallen or suffered other injuries. One person's care records we looked at showed they had sustained four falls in a four month period. It was unclear from the care records what, if any action had been taken to reduce the risk of this person falling. We also found some measures identified in the care plans that staff should take to reduce the risk of this person falling, such as encouraging them to use their walking frame were not followed. We saw this person did not have a walking frame to hand, and staff told us this person's mobility support needs had changed and that they no longer used a walking frame. This was not reflected in their care plans or risk assessments. This would increase the risk that this person would not receive the support they required in relation to mobility, which would place them at increased risk of falling.

We observed a second person was sat in a wheelchair in one of the communal lounges. We were concerned they may be at risk of falling from their chair due to their posture and because they did not have a lap belt on their chair. Their care plan and risk assessments also identified that they were at high risk of falls, and that staff should encourage them to transfer to a lounge chair. We observed this person for approximately 20 minutes and saw they were left unsupervised, and no member of staff encouraged them to transfer to another chair during this period. There was also no evidence in their care records that staff had considered whether the use of a lap belt would reduce the potential risk of this person falling from their chair, or whether the use of such equipment would be in their best-interests. We observed other instances where staff had not undertaken effective risk assessment. One person had bed rails in place, and there was no evidence of any risk assessment or regular checks carried out to ensure they remained safe. The registered manager told us the district nursing service had completed a risk assessment, and they would request a copy of their risk assessment.

The provider had not adequately assessed risks nor taken reasonable actions to reduce risks to people using the service. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we raised a concern that there was no recorded check to show that windows had been restricted to the appropriate limits to control the risk of any potential fall occurring from windows. At this inspection the registered manager told us the maintenance person had checked all the windows and found they were restricted to appropriate limits. They were not able to show us any record of this check however, and when we measured two of the first floor windows we found they opened in excess of the 100mm recommended within guidance produced by the Health and Safety Executive (HSE). Following the inspection the provider sent us a record that demonstrated appropriate checks of the windows had been completed.

During this inspection we identified other concerns about the safety of the environment. In the morning we found the door to the cleaning room had been left open, and a cupboard containing potentially hazardous cleaning materials was also unlocked inside this room. We also observed items including razors and a pair of scissors that were kept unsecured in areas freely accessible to people living at the home. We also found several radiators that did not have appropriate covers to prevent the risk of people suffering burns if they came into contact with them, and an area of torn flooring in one person's bedroom. The Belmont Care Home supported people who were living with dementia and who may have reduced ability to recognise the risks posed by such items, which placed them at risk of potential harm. We made staff aware of the issues in relation to the storage of hazardous items as we identified them, and appropriate actions were taken to move these items to safe storage.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Regulation 2014 as the provider had not ensured that the premises were safe for people using the service.

At our last inspection in January 2017 we identified concerns in relation to the safe management of medicines, which we found to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Whilst we found some improvements had been made, we found on-going issues in relation to the management of medicines, and an on-going breach of the regulation.

Medication administration records (MARs) showed that people had received their medicines as prescribed. We checked the stock of a sample of medicines and these indicated that staff had completed the records accurately and that people had not missed any medicines. The registered manager told us they had recently been made aware that people taking 'when required' (PRN) medicines should have a protocol in place that informed staff when they should administer these medicines. These had not yet been put in place, though staff told us the people they administered PRN medicines to were able to inform them when they would require medicines such as pain relief or laxatives. The lack of PRN protocols would increase the risk that staff would not know what circumstances people required PRN medicines, and that they would not be able to effectively monitor that these medicines had the intended effect.

Medicines were stored securely in a locked medicines trolley or in a lockable fridge. We saw records of the temperature of the medicines fridge and room where medicines store had not been recorded on a consistent basis. In March 2017 we saw there were seven days where temperatures had not been recorded. This meant the service was not adequately monitoring the temperature at which medicines were stored. It is important medicines are stored at the correct temperature in accordance with manufacture guidance to ensure their efficacy is not affected.

Prior to our inspection, we received information of concern that people were being left unsupervised to take their medicines. We discussed this with the registered manager who informed us there were several people they would leave unsupervised to take their medicines. The registered manager informed us these people were able to safely administer their own medicines once dispensed by a staff member. However, we checked one of these people's care records and found there was no risk assessment, or reference in their care plan in relation to leaving their medicines with them. It is good practice to support people's independence by involving them in the management of their medicines where this is their wish. However, it is important that any potential risks to that person or others living at the home are considered and clearly recorded.

These issues in relation to the safe management of medicines were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There was a lack of oversight and monitoring of the safety of the service, including accidents that occurred. There was no record that could show how many falls or other accidents had occurred at the service, or any other means of monitoring of trends, such as the time of day or location that accidents occurred. Monitoring of accidents at the level of the individual was also lacking. People's care files contained documents intended to be used to track falls and other accidents people had sustained. However, we saw in several instances that these documents had not been updated. The registered manager was also unable to show us any examples of any analysis that had been undertaken of incidents that had occurred in the home. Staff also told us accidents and incidents were not discussed with them, which meant they could not learn effectively from previous experience. This meant the provider was not able to demonstrate that they monitored or learned from accidents and incidents to help improve the safety of the service.

The registered manager told us all care staff working at the home completed care plans and risk assessments. One member of care staff we spoke with told us they did not feel they had the skills required to complete these documents, and said; "I had a little support as I went to [Registered Manager] as I didn't feel comfortable doing risk assessments and care plans. I think they should be completed by a more senior person." The registered manager told us they had completed good practice examples of care plans and risk assessments for staff to follow, but acknowledged they had also found issues with care plans and risk assessments. Given the shortfalls we identified in the safe section of this report in relation to care planning and risk assessment, we asked the registered manager how they maintained an oversight of the quality of these documents. They acknowledged they had no specific way to do this due to constraints on their time. The registered manager showed us evidence that they had booked training for nine staff in care planning. However, we also expressed concern that staff who were potentially not competent, were completing risk assessments. This would increase the risk that these important assessments would not recognise potential risks to people's health and wellbeing, and that reasonable measures to reduce such risks would not be put in place.

At our last inspection in January 2017 we found records of 'low level' safeguarding concerns that required submitting to the local authority on a regular basis had not been completed since October 2016. At this inspection the registered manager informed us these logs had not been updated since our last visit. This meant the registered manager did not have a clear record of concerns arising at the service, and meant they would be unable to monitor and take action in relation to any emerging trends. The local authority informed us they had planned time to spend with the registered manager to support them in the requirements around the completion of the 'harm level logs'.

We found the water temperature of one of the taps we tested felt very hot. The registered manager informed us the water outlets were on thermostatic valves, which should prevent the water from reaching an unsafe temperature. However, it is important to check water temperatures in case such equipment fails. The registered manager was not able to show us any records of water temperature tests, as they said the maintenance person held these, and they were not in work on the day of our inspection. We requested the registered manager send these records following our inspection, which indicated water temperatures were

within recommended guideline limits. However, the check of water temperatures had not been completed in March 2017 on the record of monthly water temperature checks we received.

The preceding four paragraphs demonstrate that the provider was not adequately assessing, nor taking action to improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our last inspection we requested, but did not receive, copies of audits carried out by the provider. The registered manager told us they had not yet received copies of these audits from the provider. The registered manager told us that although they felt supported by the provider, the director of the company did not have a background in social care and they were not always sure where to go to for support. They informed us they were looking into alternative sources of support such as contact with other registered managers in the area, and on-line resources for registered managers.

Staff spoke positively about the registered manager, but told us they did not think the service was well-led and did not feel well supported due to the workload of the registered manager. One member of care staff told us; "I don't think there's enough management. When we have concerns there is no-one to ask. [Registered manager] is approachable, but has too much to do." At our last inspection the registered manager told us they frequently worked long hours, and they told us this had not changed. We found a second member of administrative staff had started on the day of our inspection, and the registered manager told us they continued to actively recruit for a deputy manager. The registered manager told us they expected this to assist the effective management of the home.

Staff told us they had not been given opportunity to attended staff team meetings on a regular basis, and said communication at the home was poor. One staff member told us they had only found out about the findings from the Care Quality Commission's (CQC's) last inspection by checking our website. Care staff told us they did not attend shift handovers with senior carers, and that information was not always passed to them from these meetings. They told us they were expected to read the communication book to ensure they had received all required messages, but that this was often not practical.

We reviewed records of staff supervisions, which showed 15 out of 20 care staff had received a supervision in the previous six months. One staff member we spoke with told us they had not received a recent supervision or appraisal in the past 12 months, and we were also unable to locate any record of them having received supervision. We requested, but did not receive an overview of when staff had received their last supervision and appraisal. The registered manager completed appraisals with the assistance of a third party human resources company, and a member of the administrative staff completed staff supervisions. At our last inspection, the registered manager assured us the member of administrative staff had the appropriate skills and qualifications to enable them to provide effective supervision to staff. However, at this inspection we found staff did not always feel well supported, and one staff member questioned why a member of administrative staff was providing their supervision. Supervision is an important tool to support staff, allow opportunity for reflective practice, and to monitor their competence.

The provider had failed to ensure staff received adequate support and supervision to undertake their roles competently. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that she and the provider had recently attending training in relation to CQC's regulation. She also informed us that they had arranged for a 'mock inspection', which would help them further understand the areas of the service that required additional attention. However, we found the

registered manager did not have up to date guidance in relation to meeting the regulations of the Health and Social Care Act. It is important that providers and registered managers are aware of the relevant guidance and legislation to ensure the service they provides is meeting legal requirements and the fundamental standards for provision of care.

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 18 HSCA RA Regulations 2014 Staffing Staff did not received appropriate support and supervision to undertake their role competently. Regulation 18(2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have adequate systems and processes in place to assess, monitor and improve the safety of the service. Regulation 17(1)

The enforcement action we took:

We served a warning notice to the provider and registered manager