Almondsbury Care Limited

Belmont House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Belmont House Nursing Home is a residential care home providing personal and nursing care. The service can support up to 40 people. There were 19 people living in the service at this inspection.

People's experience of using this service and what we found
We last inspected the service in November 2020. Since this time the management situation has not improved. Before the inspection we were aware the previous manager had resigned. A new manager had been in post for five weeks, however they had yet to start the registration procedure with CQC.

There has been a lack of consistent management of the service since December 2019. The senior management had also changed and currently there was no senior manager or representative of the provider visiting the service to support the new manager. Systems and processes were being frequently changed and not effectively implemented or embedded.

At the last inspection it was noted that things had started to improve. However, at this inspection we found this not to be the case. This included failings in the assessing and monitoring of the safety and quality of the service which had deteriorated. Systems to ensure compliance with regulations for example in regard to audit systems, infection control and staff training, deemed as mandatory, were neither consistently applied, or effective to ensure the service was managed to a good standard.

Good practice regarding infection prevention and control was not being followed, particularly in relation to enhanced procedures required to protect people due to the pandemic.

The service had a Covid-19 outbreak, starting in January 2021. Since this time the senior manager, manager and many nurses, care staff and ancillary staff had left the service. Staff were not always recruited in sufficient numbers to keep people safe. We were aware of the staff shortages, some due to the outbreak. However, some were due to ongoing vacancies not being filled. Staff said there had been many staff shortages and the manager admitted there was a high reliance on agency staff. During the recent outbreak the local authority were supporting the manager to find staff to cover shifts. The manager said they were taking steps to improve recruitment including nurses, carers and ancillary staff. Staff were observed as attentive, kind and caring.

A relative contacted us as their loved ones wishes, on their death, had been ignored. They were distressed that though the service had clear instructions on their loved ones wishes it was then too late to implement them. The manager who had not been in post at that time agreed lessons would be learnt from this.

A relative had requested their loved ones notes and had been sent notes belonging to another person causing this family distress. The manager said they would action the correct notes being sent.

At a previous inspection we made a recommendation about how staff accessed training. At the last inspection in November 2020 we found support was in place for staff to complete online training. However, since that time staff training had not always been completed. Staff were still required to complete mandatory training including infection control. Staff told us support from the new manager was good.

We received feedback from healthcare professionals and relatives that changes in people's health was not always escalated to the relevant professional and relatives were not always kept informed. One healthcare professional said they had called the home and were unable to obtain the current clinical information about the person they called about. They had also spoken to the manager who was unable to tell them the current health condition of people as they 'did not know them'.

We received information of concern that some staff were using restrictive practices. The manager confirmed no staff at the service were using these practices as no staff employed at the service had completed this training.

People were relaxed and comfortable with staff and had no hesitation in asking for help from them. Staff were caring and spent time chatting with people as they moved around the service.

People we spoke with were all happy with the service. One person said. "They are kind" and another who remained in their bedroom, when asked, said the staff called into see them regularly.

The home had introduced a new computerised care plan system. Therefore, when people's needs had been assessed as needing to have specific areas of their care monitored, such as their weight, food and fluid intake, skin care and re-positioning records of these checks, had improved.

The manager confirmed all risk assessment were now completed and stored on the new computerised care system. However, risk assessments to enable visitors to visit their loved one safely had not been completed.

There was an activity worker in post to carry out some activities with people. Staff spoken with were passionate about what they do, and said, "We have supported each other to get through a very difficult time." This was in reference to the Covid outbreak and the unfortunate deaths of many of the residents.

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

Rating at last inspection
The last rating for this service was requires improvement (published 01 January 2021). The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

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

Why we inspected
The inspection was carried out to check if standards had been maintained in relation to the management and safety of the service. We carried out this focused inspection to review the key questions of Safe and Well-led only.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to Coronavirus and other infection outbreaks effectively.

Follow up
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

You can see what action we have asked the provider to take at the end of this full 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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well-led findings below.

Belmont House Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by one inspector.

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

The service did not have a registered manager in post. The provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgments in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke to two people during the inspection about the care they received. We spoke to four staff members. We reviewed a range of records. This included two people's care records and three medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We asked for, though never received training data. We spoke with three professionals who have been working with the service and received feedback from two relatives.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now changed to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- We were not assured that the provider's infection prevention and control policy was up to date. Although the building was clean, no policies and procedures in relation to Covid 19 were in place. Washing facilities, signage and Personal Protection Equipment (PPE) were available. The visiting policy had not been updated in line with new government guidelines allowing one nominated visitor. A follow up call with the manager confirmed this had been actioned including a separate visiting room. No policy had been updated to include people who were deemed end of life care, to have visits by relatives during the recent Covid outbreak. However, a follow up call confirmed this had been implemented.
- We were somewhat assured that the provider was making sure infection outbreaks could be effectively prevented or managed. The service had a major outbreak in the early part of the year which included the loss of people living in the service and most people and staff having caught Covid. The service did not have a designated doffing and donning room available for staff. However, they did have use of a toilet area. There was conflicting information from staff about the wearing of uniforms to work. One staff member said they changed from ordinary clothes to their uniforms when they came on duty. While another said they wore their uniform into work. The manager said it was policy for staff to change when they came on duty. The manager confirmed during a follow up call that a staff meeting was held to inform staff of the process that needed to be followed. The service was well supported by the local authority on a daily basis including, staff support, PPE equipment and visits by a Covid outbreak specialist to support the management team.
- We were assured that the provider was preventing visitors from catching and spreading infections. Due to the outbreak no visitors had visited the home. Anyone now entering the service received an instant result Covid test and would only be able to enter if this was negative.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

We have also signposted the manager to resources to develop their approach. For example, the manager did not know the date they were due to come out of whole home isolation after their outbreak. We advised them to speak to Public Health England and the local authority for this date. We also received feedback from a professional who had told us of making many attempts to contact the service to book Covid vaccinations

for people and staff who were now out of isolation. They went onto say it had taken nearly six weeks for the service to obtain support from people's relatives to agree to the vaccinations. A follow up call to the manager confirmed these vaccinations were now booked.

Staffing and recruitment
● There were enough staff on duty to meet people's needs. However, the majority of these staff, including the clinical lead were employed from an agency.
● Staff were responsive to requests for assistance and recognised when people needed support. Staff had enough time to engage with people in a meaningful way.
● Since the last inspection many staff had left the service. These vacancies were still to be filled and included nurses, care staff, laundry, maintenance and cook. Therefore, shifts were filled by regular agency staff who were currently only working at this service.
● The manager confirmed they were in the process of staff recruitment; however, this was proving difficult.

Systems and processes to safeguard people from the risk of abuse
● We received information of concern that some staff were using restrictive practices. The manager confirmed no staff at the service were using these practices as no staff employed at the service had completed this training.
● People were relaxed and comfortable with staff and had no hesitation in asking for help from them.
●The provider had effective safeguarding systems in place. Safeguarding policies and procedures were available and the manager notified us of any concerns. Staff knew how to report and escalate any safeguarding concerns.

Assessing risk, safety monitoring and management
● The service had suitable risk assessment procedures in place, for example, risks in regard to peoples nutritional and fluid needs. However, risk assessments in relation to relatives visiting their loved one in line with new government guidelines, had not yet been completed.
● Where people were assessed as being at risk of pressure damage to their skin integrity, information was held on the electronic care plan systems. Staff confirmed they had easy access to this information on hand held devices. These were used to document when people received personal care including re-positioning if confined to bed and when they received food or fluids.
● Some people had been assessed as needing pressure relieving mattresses to protect them from skin damage. The manager confirmed staff checked to ensure these devices were always set correctly but audits had not been completed regularly due to not having regular staff to carry out this task during the recent outbreak.
● Electronic devices held information on people who were at risk of losing weight. One staff member said the general wellbeing of people had improved since recovering from Covid and people's appetites had started to improve. They said people had now started to eat better and put on weight. Staff confirmed people's weight was being checked regularly and recorded. Previously the weight measurements of people had not always been completed, due to most people being ill or the service having agency staff only on shift.

● The environment needed some upgrading, this included the heating system. This had been a major issue over the winter months with the heating frequently breaking down. An assessment of the heating system had taken place some weeks ago. The manager confirmed they had not yet received the result of that assessment. The service had resorted to portable heaters, borrowed from the local authority to keep people warm during cold periods and when people were very ill due to the Covid outbreak.

Using medicines safely

● Systems for administering, storage and monitoring medicines were safe.
● Medicines were regularly checked by senior staff to ensure no errors were being made.
● Medicines were kept securely in locked trolleys and cupboards. Stock levels were satisfactory, and staff said there had been no supply problems throughout the period of the pandemic.
● Medicine records were fully completed and well organised.
● When medicines were prescribed for use 'when required' there was sufficient written guidance for staff to know when these medicines should be given.

Learning lessons when things go wrong
● In respect of concerns raised (above), the manager, who had only been in post for five weeks was taking suitable action to review current procedures, and assured us that changes had either been made, or plans were in place to ensure changes would occur.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

At our inspections in November 2019, July 2020 and November 2020 the provider had failed to establish satisfactory governance arrangements. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The service is required to have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of this inspection the service had not had a registered manager since the beginning of June 2020. The current manager had only been in post for five weeks. The previous manager in post at the last inspection, left before completing their registration process. The new manager had not made an application at the time of this inspection.
● There had been a lack of consistent management of the service since a long-standing manager left in December 2019. Between the long-standing manager and the current manager there had been three other managers for short periods. This had caused systems and processes to be frequently changed and not effectively implemented or embedded.
● There had also been a change of senior provider management since the last inspection. With no visiting senior manager in post since the previous one had left. The current manager was now receiving telephone support from other management in the company. However, professionals involved with the service, in particular when the outbreak started, stated this had not always been consistent.
●Due to the implementation of a computerised care planning system the assessing and monitoring of the safety and quality of the service was satisfactory. However, the manager confirmed auditing systems for the provider and manager to have oversight of the service, were not being carried out regularly due to the outbreak and lack of consistent staff in post.
● Roles and responsibilities needed clarity. A new Chief Operations officer was due to start and would work with the manager and support them to action all issues raised in this report. The manager had employed a new clinical lead, however they had only been in post for three weeks.
● Systems were required to pass on important information about changes in people's care needs to the

relevant professionals. The manager felt this would come with the appointment of the new clinical lead and when they filled vacant posts.

Working in partnership with others

● Information was received from professionals about the lack of provider level involvement in the service and also during the early part of their outbreak of Covid.

● We received information from three healthcare professionals that the service was not working effectively with them to ensure people's care needs were met. They stated that it had become increasingly difficult to engage with management and staff over the clinical wellbeing of people in the service. They went onto say that at times when they spoke to nurses' and other staff members they often did not know any details about that person concerned. The new manager felt this was due to the high levels of agency workers in the home.

● Since starting in post the new manager had worked closely with the local authority's Covid Outbreak team. They offered, among other things, support to the new manager, filling staffing shifts which the provider had not been able to fill and obtaining additional PPE and Covid tests for people and staff.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.

● The provider had not notified CQC of the deaths of people living in the service in line with the regulations. After the inspection we spoke to the new manager about this issue. They agreed to action this, and complete notifications as required.

Continuous learning and improving care

● Training has not been updated for all staff as required. The manager said they had set up staff on the on-line training system to enable all staff to carry out mandatory training. This would help to ensure all staff were trained to the same level, so the care provided to people was consistent.

We found no evidence that people had been harmed however, the provider had failed to establish satisfactory governance arrangements. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.