Amber Blossom Limited

BELVOIR HOUSE CARE HOME

Inspection report

Brownlow Street
Grantham
Lincolnshire
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Tel: 01476565454

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The Inspection took place on 12 November 2018 and was unannounced.

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

Belvoir House Care Home provides accommodation for up to 24 people living in one adapted building. The home provides care for older people some of who may be living with dementia. There were 20 people living at the home when we inspected.

There was no registered manager in post at the time of our inspection. 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.

This was the first inspection of the home since the provider purchased it. Therefore, this is the first time the home has been rated Requires Improvement.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Care plans contained the information needed to support staff to provide care tailored to people's individual needs. They also contained the risk assessments to minimise the risk to people while receiving care. However, pressure care was not always provided in line with the risk assessments. People received coordinated care at the end of their lives as the staff worked with healthcare professionals to ensure people received the care needed at this time of their lives.

The number of staff needed to care for people was assessed but due to sickness people were late receiving their care. Recruitment processes ensured that staff were safe to work with people living at the home. Staff received the training and support needed to provide safe effective care. Policies were in place to support effective care. Staff knew how to keep people safe from the risk of abuse.

People were offered a choice of meals and were supported to eat safely and maintain a healthy weight. Medicines had not always been available to people and recording of medicines did not always support the safe management of medicines. The home was clean and staff knew how to use protective equipment to keep people safe from the risk of infection.

Staff were kind and caring and took the time to get to know people. They offered people choices in their lives and involved people in their care. People's ability to make decisions was assessed. However, when

people had arranged for others to make decision on their behalf the paperwork to confirm this was not available. At times people's dignity was not maintained. Activities were provided, however at times the activities may not be supportive of people living with dementia.

Systems to monitor the care people received had not identified the concerns around the management of medicines. However, they had identified all the other concerns we found. In addition, complaints and incidents had been investigated and action had been taken to improve the safety and quality of care provided. The environment did not support the needs of people living with dementia and was not maintained to an acceptable standard. In addition, linen in the home was in poor condition.

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 consistently safe.

Care plans contained risk assessments to keep people safe. However, care was not always provided in line with the risk assessments.

The number of staff needed to care for people was assessed but due to sickness people were late receiving their care.

Medicines had not always been available to people and recording of medicines did not always support the safe management of medicines.

People were safeguarded from the risk of abuse.

The home was clean and people were protected from the risk of infection.

Incidents were analysed, and action taken to reduce the risk of reoccurrence.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The environment did not support the needs of people living with dementia and was not maintained to an acceptable standard.

People's ability to make decisions was assessed. However, when people had arranged for others to make decision on their behalf the paperwork to confirm this was not available.

Staff received the training and support needed to provide safe effective care. Policies were in place to support effective care.

People were supported to maintain a healthy weight and to eat safely.

People were supported to access healthcare professionals when they were ill.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity was not always supported.

Staff were kind and caring and took time to get to know the people they cared for.

People were offered choices in their lives

Is the service responsive?

Good

The service was responsive.

The care provided met people's needs.

Activities were provided to support people's wellbeing.

People's end of life wishes were identified and respected.

Complaints were investigated and changes made to improve the care people received.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was no registered manager for the home.

Systems to monitor the care people received had not identified the concerns around the management of medicines.

People had been asked for their views on the care provided.

BELVOIR 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 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 12 November 2018 and was unannounced. The team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In preparation for our visit we reviewed information that we held about the home. This included notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams.

On this occasion, we had not asked the provider to send us a provider Information return (PIR). A PIR is a form that asks the provider to give some key information about the service. This includes what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt was relevant.

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.

We spoke with the area manager, the deputy manager, a senior care worker, a care worker, the cook and the housekeeper. We spoke with a healthcare professional who visited the service while we were there and with eleven people living at the home and three visitors to the service.

We looked at a range of documents and written records including three people's care files and two staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that they felt safe living at the home. One relative told us, "She is safe, yes. She walks around a lot and is always wanting to go out but they [staff] keep a good eye on her." Another relative told us, "I do feel he is safe, definitely. When he's had any little accidents like falling out of bed they put a crash mat by his bed with an alarm, so he was safe." Staff monitored people and provided assistance to ensure people were safe as they moved around the home, providing constant encouragement and reassurance to people.

Care plans contained the information needed to support staff to provide safe care to people. For example, where people were at risk of falling out of bed care plans recorded that their bed should be lowered and a mattress put at the side of the bed to reduce the risk of injury. However, we had recently received a number of notifications in regard to pressure sores. A community nurse we spoke with felt that at times staff were not always recognising the early signs of pressure damage. In addition, we saw that two people who had been provided equipment to protect the skin on their heels, had not been supported by staff to use the equipment.

The registered manager told us that they had established how many care staff and other members of staff needed to be on duty. They said that they had taken into account the number of people living in the service and the care each person needed to receive. We saw that call bells were answered promptly during our visit. However, due to sickness they were a member of staff down on the day we visited and we saw that this delayed people's care. For example, we saw that some people were not assisted to get up until 11:45am and medicines were also late being administered. Staff told us to minimise the impact on people they had considered who liked to get up early and prioritised those people over people who preferred to take their time getting up. In addition, the mid-morning drinks and snacks were not offered to people until 12pm.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. Any gaps in people's employment history had been identified and investigated. The required checks had been completed to ensure that staff were safe to work with people who live at the home.

Records showed that people had not always been supported to take their medicines as prescribed. We found that medicines prescribed to be taken as required had not been reordered in a timely fashion and therefore were not always available to people when needed. For example, we saw one person's laxative had not been available for them for over a week. In addition, we also found that there was not always information available to support staff to administer medicines prescribed to be taken as required in a consistent manner. For example, records did not record if people were able to tell staff if they were in pain or if they needed staff to monitor them as they may show their pain through their body language. We raised both these concerns with the area manager and deputy manager. They told us they would take immediate action to resolve the concerns identified.

We checked the Medicine Administration Records (MAR) and saw that they had been completed. In addition, we saw they contained the information needed to support the safe administration of medicines. However, we saw that the actual time of administration had not been noted. This was important as medicines had been administered late that morning due to staffing issues. Recording the actual time of administration would ensure that staff where aware of when the next dose could be given. In addition, we saw that where medicine needed recording on the MAR and in a separate book to comply with legal requirements, both entries were not always completed.

People told us that they felt the home was clean. One relative said, "You don't come in and regularly smell a "care home". Obviously occasionally they have accidents but that's sorted very quickly." There was a cleaning schedule in place and it identified daily, weekly and monthly tasks to be completed. Records showed that cleaning had been completed in line with the schedule. Clinical waste was disposed of safely.

Staff told us that they had completed training in keeping people safe from the risk of infection. They were able to tell us about how they kept people safe from infections by using protective equipment and washing hands. One member of staff had been identified as the infection control lead and had received training to support them in their role. In addition, they attended local authority meetings which ensured that they kept up to date with best practice.

We found that the area manager and deputy manager had established suitable arrangements to enable lessons to be learned and improvements made if things went wrong. This included carefully analysing accidents and near misses so that they could establish why they had occurred and what needed to be done to help prevent a recurrence.

People told us that they felt safe in the home and relatives felt that the home was a safe environment for their family members. One person told us, "I have a button in my room, they are very good, they come within a short time." Another person said, "They [staff] pop in to check on us at night time. We have buttons which you can send for them if you fall or need anything, they come when they can, they might be busy but you don't wait long."

We found that people were safeguarded from situations in which they may experience abuse. Records showed that care staff had received training and knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. We discussed with the area manager a safeguarding they had raised and were confident that they had investigated the incident and taken appropriate action to keep the person safe. In addition, they had told the relevant external agencies about the concerns so that all necessary steps were taken to keep people safe.

Requires Improvement

Is the service effective?

Our findings

We found that the accommodation was not designed or adapted to meet people's needs. There was a lack of signage to help people with dementia with move around the home independently and a lack of other dementia friendly decoration to support people to recognise their bedrooms. For example, all people's doors were the same colour and the door numbers were dull brass and mounted some six feet off the floor making them difficult for people to make out. Some rooms did have memory boxes showing the occupants name and some relevant images mounted by their doors but these were small and again at a height which appeared inappropriate for people in the home.

We found that the home was not always maintained to a high standard and there were some safety concerns. For example, down one corridor there were a large number of screws and hooks which were not being used. They were at a height where people may put their hands or lean against the wall and injure themselves. In addition, we found that some rooms needed decorating. For example, a wall in one room had been half painted and you can see that the paint did not match. In another room we saw the ceiling had been patched and needed decoration. We also saw that an ensuite carpet had been removed and was left with bare floorboards.

Furniture in the home had not always been maintained to a high standard and people had mismatched furniture in their room. For example, some armchairs were worn and would not provide adequate support for people. We found one set of drawers where some of the fronts were missing and another set which did not have any handles. Most rooms lacked personalisation and did not reflect the people who lived in them.

We discussed these concerns with the area manager. They told us that there was a plan in place to redecorate the home and to improve the experience for people living with dementia. They had received a grant to help them with the work.

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

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

The area manager had ensured that there were systems in place to assess if people were able to give informed consent to living at the home. Where people had not been able to give their consent appropriate

DoLS applications had been submitted. No one at the home had any conditions of their DoLS.

Where people did not have capacity to make decisions for themselves. Care staff, family members and healthcare professionals worked together to make decisions in their best interest. We saw in one person's care plan that they had made legal arrangements for a family member to make their decisions for them. However, the area manager had not ensured that the documentation confirming this arrangement was in the person's care plan. This meant that healthcare professionals could not be confident that the family member had the appropriate legal authority to make decisions. We saw that on one occasion healthcare professionals had made a decision in the person's best interest instead of taking note of the legally responsible family member.

We found that robust arrangements were in place to assess people's needs and choices so that care was provided to achieve effective outcomes. These were not always completed by a member of staff from the home as the provider was part of a trusted assessor scheme. This was where hospital and social care staff would complete the assessment and share the information with the home. Gathering this information before admission meant that the area manager and deputy manager were able to identify if they could meet people's needs in a safe manner.

The provider had policies in place to provide staff with guidance on how to provide safe care in line with best practice. The area manager told us that they were currently reviewing the policies to ensure that they were up to date with changes in guidance and legislation. They told us that they would cascade any changes to staff through team meetings.

Records showed that new care staff had received introductory training before they provided people with care. This included reviewing the provider's policies, completing mandatory training and working alongside experienced staff. In addition, staff new to care were required to complete the care certificate. The care certificate is a national set of standards that staff need to achieve to provide safe care to people.

Staff also received on-going refresher training to keep their knowledge and skills up to date. The area manager had a list of staff and when their training was due. Staff received reminders of what training they needed to be completing. Records showed that the required training had been completed by staff.

Records also showed that the provider had completed regular individual meetings with staff to discuss their work. The area manager told us and records showed that where they had identified concerns around staff abilities an improvement plan had been designed for staff to support them to become more competent in required areas.

We saw that the meals were well presented and looked appetising. People told us they were happy with the food provided in the home. One person told us, "I enjoyed it, the meals are all very good." Another person told us that the food was "Not bad and we get enough." People were offered hot and cold drinks throughout the day. For example, we saw that as people were seated at the dining room tables they were immediately offered a drink of juice. We saw that they had a choice of three flavours and that carers explained this choice by showing people the cartons where appropriate. After lunch people were offered a hot drink and again were given a choice.

Staff were aware of people's needs and abilities around their food and offered help to people if needed. For example, during the meal staff asked people if they wanted help to cut their meat and waited for a positive response before giving assistance. When people finished their meals staff asked them if they wanted any more. Those people who had left some of their meal were asked if they had had enough. We saw that one

person was encouraged to eat more but that when she said she did not want any more this was respected by staff.

People's weights were routinely monitored and audited to ensure that they maintained a healthy weight and action was taken should any concerns be identified. For example, people were referred to their GP for advice and support. In addition, records were kept of their food so that the information could be shared with healthcare professionals and used to assess if any supplements were needed.

People's care plans contained the information needed to ensure they ate safely. For example, some people needed a textured diet. This is where food is either cut up small, mashed or purred and is needed when people are unable to swallow whole food safely. Where needed people had been referred to healthcare professionals for advice on the type and consistency of the food they could safely eat.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. The senior team leader role had been put in place to ensure that there was effective communication between the home and other healthcare professionals. When people were admitted to hospital staff ensured that an overview of their care needs and medicines, and any advance decisions which had been made about their care were transferred to the hospital with them.

People were supported to live healthier lives by receiving on-going healthcare support. People told us that their health needs were handled well in the home. A relative told us, "She lost weight when she was seriously ill and paramedics said that it was near the end but she looks well now. They [staff] always phone me if they have any problems, they are very good at keeping us informed. They have a dedicated nurse from the surgery come in, they have an optician come in and a chiropodist comes as well." Another relative said, "He's well looked after if he needs any attention urgently. He has episodes when he goes nearly unconscious and they [staff] get the paramedics straight away. They are always quick to ask for help for him."

Requires Improvement

Is the service caring?

Our findings

Relatives told us that people's dignity was supported. One relative said, "If they spill things on their clothes they quickly change them." Another relative told us, "They look after her, keep her clean and always shower her quickly if she has an accident." However, we found that people's dignity was not always supported. For example, we saw that one person's care plan noted that a person was to be supported to wear their glasses. Without them the person would struggle to communicate their needs and would get frustrated. However, we saw that this person's glasses were in their bedroom.

Additionally, we found that people and their relatives had concerns over laundry. One relative told us, "The only problem I have is they can never find her clothes. I've brought lots in but they can never seem to find them when I come, say they are in the laundry and that." We saw that people's clothes were not always treated with respect as drawers were crammed full and would not shut and clothes were not put away neatly. We saw that linen such as towels and bedsheets were old, worn and some towels had ragged edges.

We saw that the service ensured that people were treated with kindness and that they were given emotional support when needed. When staff helped individuals they also engaged with all the people already in the room and that there was a stream of conversation and friendly banter. A visiting relative told us, "They [staff] are all very pleasant and helpful, I can't fault anybody, I can't fault the care."

The mealtime was an enjoyable social occasion for people. Staff were attentive to people during the meal and took the time to engage socially with people and there was a lot of laughing. We saw that all the staff took time to support people. For example, during lunch the housekeeper came into the dining room to talk with people. We saw that while she did this she asked people if they wanted their drinks topping up and then did this. The area manager also spent time with people while they were eating. They had a good rapport with people and that people appeared comfortable with them.

People told us that staff at the home were caring. One person told us, "The people who work here are very good, very nice. I've no complaints about that side of things." Another person said, "They are all very nice, they work hard." A visiting relative told us, "I like it here, it is friendly and they do care. The carers are all nice, kind to the residents, are always cheerful." All interactions from staff with people we saw were positive social interactions. We saw lots of appropriate touching, such as hand holding and stroking. In addition, we saw that staff would ensure they gained eye contact from the person before engaging with them ensuring that the person was happy and comfortable.

We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. For example, we saw that people were offered choices about where they wanted to spend their time and eat their meals. People were offered two choices of main course and two choices of sweet and they were asked to make a decision during the morning so that the cook could plate the meals accordingly. However, the cook told us that if people did not want either choice then they would cook anything they wanted for them. Relatives confirmed that people were offered choices through the day one relative told us, "They get her up and get her breakfast when she wants. They'll

get them ready for bed and they'll sit them in the lounge in their night clothes if they want that but they can go to bed when they want."

People's privacy was respected and promoted. We saw that staff knocked on doors before entering. Suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff.

Good

Is the service responsive?

Our findings

We found that people received personalised care that was responsive to their needs including their right to have information presented to them in an accessible manner. Consideration had been given to how information was available to people in an accessible format to ensure this was meaningful to people. All organisations that provide adult social care are legally required to follow the Accessible Information Standard. The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people who use services. The standard applies to people with a disability, impairment or sensory loss and in some circumstances to their carers. Records showed that during the initial assessment, people's ability to communicate were assessed.

People and their relatives had been involved in planning their care. One relative told us, ""I've had chats with the manager about what (family member) needs. They are trying to help me with social services." In addition, the area manager told us that they had started a review of all the care plans. They had invited people and their relatives to the review of care so that their views could inform any changes needed to the care plan.

We saw that care plans contained all the information needed to support staff to provide safe effective care. In addition, staff we spoke with were knowledgeable about people's needs and reflected the information recorded in the care plans.

The activity coordinator worked four days a week. They were completing some training in dementia and was a member of NAPA (National Activity Providers Association) and as such had access to training, literature and ideas to help her develop activities for people. The activity coordinator planned a monthly programme of activities in advance but was able to be spontaneous depending on how people feel on the day. They told us, "We have a variety of activities and change these but there are one or two which the residents like, like bingo and the singing so I do these every week."

People showed us and records confirmed that they were offered the opportunity to pursue their hobbies and interests and to enjoy taking part in a range of social activities. However, we saw that in the main lounge there was a television at each end of different channels both on with no sound and then loud music was on. This environment was not calming or relaxing and would have been very confusing for people living with dementia and could increase their distressed behaviour. One person living at the home told us, "I like to watch TV, and listen to it but they always have the music on too." A visiting relative commented, "This activity coordinator just makes a noise, it is like this [Loud music coming from the lounge] all the time, it is very, very noisy. But I accept a lot of residents like it."

Other people were positive about the activities offered. One person told us, "I read a lot, do a lot of crosswords. There is a person [activity coordinator] who comes in two or three times a week and encourages people to sing, paint or do crosswords. She gets people doing things, she's quite good." A relative said, "They play lots of floor skittles, they do jigsaws. They do a lot of singing, I think a choir comes. The activity lady planted bulbs and those that could helped but she included everybody, showed them all."

One person had found some peace and quiet sitting by their self in the dining room during the morning. A member of staff had offered them a magazine to read but this was not an ideal room for relaxation. The member of staff later explained to us that this person did not always want to move into the lounge or socialise and could be aggressive if this was suggested or encouraged so staff let her sit in the dining room but 'remained attentive'.

Suitable provision had been made so that people could be supported at the end of their life to have a comfortable, dignified and pain-free death. People's wishes at the end of their lives had been discussed. A relative told us, "I haven't discussed an end of life plan but have said I don't want [name] taken to hospital if it can be avoided and they've done that, paramedics came and treated him but he stayed here." Records confirmed that people's end of life wishes had been discussed and recorded and that the staff had liaised with other healthcare professionals so that people were fully supported at the end of their lives.

There were arrangements to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. The home's complaints procedure was displayed in the foyer. No one we spoke with had made any formal complaints to management nor had felt the need to. However, they had felt able to raise concerns in an informal manner and were happy that they had been resolved to their satisfaction. One relative said, "I have no real issues, they used to keep losing things, everything kept disappearing but that's better now."

Records showed that two formal complaints had been received. The area manager had investigated both complaints and had taken appropriate action to resolve the concerns.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager for the home. 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. The previous registered manager had become the area manager and had deregistered on 21 September 2018. They told us they were in the process of appointing a new manager for the service.

We found that systems were in place to monitor the quality of care provided to people. These systems were meant to ensure that the home was safe for people and that care met people' needs and followed best practice guidance. We raised the concerns around medicines with the area manager and they took action to resolve the issue immediately. All the other concerns we found had already been identified as issues by the area manager and deputy manager and plans were in place to improve the care for people.

People told us that the area manager and deputy manager were approachable and that they could talk to them about any issues they had. One person told us, "They are very busy sometimes but they'll always speak to you." A relative told us "The manager is very approachable. There have been some changes and she seems very nice, always makes a point of talking to you when you come in."

We noted that the area manager had taken a number of steps to ensure the service's ability to comply with regulatory requirements. Records showed that the registered persons had correctly told us about significant events that had occurred in the service. Although the home had belonged to a different provider at the time of the previous inspection. We saw that the registered persons had suitably displayed the quality ratings we gave to the service at our last inspection. In addition, information on how to contact the provider was on display in the home in case people wanted to talk with them directly.

We found that people who lived in the service and their relatives had been engaged and involved in making improvements. There had been a residents' and relatives' meeting in May 2018 and the area manager told us that they were looking at holding meetings twice a year. In addition, quality assurance surveys had been sent out to people living at the home and their relative in October 2018. The area manager was waiting for their return so they could analyse the results. While people we spoke with could not recall attending the meeting they were clear that they could speak with the area manager or deputy manager at any time. A relative told us, "I think that [residents' meeting] is something that may be on the cards with the new manager. They [management] are in flux at the moment but I know I can always ask or arrange a meeting one to one if I need."

We found that the area manager had made a number of arrangements that were designed to enable the service to learn and innovate. Staff were supported to keep up to date with changes in the home through staff meetings. In addition, they could discuss any concerns or changes in the home at their supervisions. A member of staff told us that she was fully supported in her role by management saying, "I do feel supported by the manager and if I have any concerns I can go to her. I had a one to one supervision session."

We found that the service worked in partnership with other agencies to enable people to receive 'joined-up' care. The area manager and deputy manager worked to establish and maintain relationships with healthcare professionals so that they could work together to care for people.