Vitality Care Homes Ltd

Belgrave Court Residential Care 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
Belgrave Court Residential Care Home provides accommodation and support with personal care for up to 30 older people, some of whom may be living with dementia. At the time of this inspection there were 24 people using the service.

People's experience of using this service and what we found
People were not receiving a service that provided them with safe, high-quality care. The service was not consistently well-led. Quality assurance systems failed to identify all the improvements required within the service.

The provider had failed to ensure government guidelines for working safely in care homes during the COVID-19 pandemic were implemented and adhered to.

There were gaps in recruitment checks, and staff training.

People were supported by enough staff and appeared comfortable and happy with staff interaction with them.

There had been clear improvements made to the safe management of people's medicines, and how people, and their relatives were consulted and engaged with about their views of the service.

Improvements had been made and were ongoing to ensure peoples care plans and risk assessments contained information about their healthcare risks and reflected their current needs.

For more details, please see the full report which is on the Care Quality Commission's (CQC) website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Inadequate (published 13 November 2020). There were breaches of Regulation 9 (Person-centred care), Regulation 12 (Safe care and treatment), and Regulation 17 (Good governance) for which we issued a warning notice.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

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

This service has been in Special Measures since 13 November 2020. At this inspection the provider

demonstrated that some improvements had been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an announced focused inspection of this service on 27 August, 01 and 17 September 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve Person centred care, Safe care and treatment, and Good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements.

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 COVID-19 and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Belgrave Court on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to infection prevention and control, and governance of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Belgrave Court Residential Care 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
One inspector visited the home, and two inspectors spoke with staff and relatives over the telephone.

Service and service type
Belgrave Court Residential Care 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 manager registered with the CQC. 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. A manager had been at the home since November 2020. They had applied to become the register manager.

Notice of inspection
We gave a short period notice of the inspection because of the risks associated with COVID-19 and to ensure everyone remained safe during our inspection site visit.

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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with the manager, and deputy manager. We observed staff interactions with people. We reviewed a selection of records; this included two people's care records, and the provider's arrangements for managing medicines.

After the inspection
We requested further information be sent to us, this included recruitment records, care plans, training data, quality assurance records, and a selection policies and procedures. We continued to seek clarification from the provider and manager to validate evidence found and spoke over the telephone or corresponded via email with five staff members and four people's relatives. We shared our findings with other professionals, so they were aware of risks at the service and the safety concerns we identified.

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 Inadequate. At this inspection this key question has improved 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 people could be harmed.

Preventing and controlling infection

- People were not protected from the potential spread of infection.
- No health screening was completed for anyone living in, or entering the home for symptoms of COVID-19. This meant that people, staff and visitors were not protected from the spread of infection.
- People were not encouraged to social distance increasing the risk of them catching or spreading COVID-19.
- Personal Protective Equipment (PPE) was not easily accessible to staff throughout the building, so they could change this when required. There were no specific areas for staff to put on and remove their PPE safely.
- Staff did not always follow good practice guidance in relation to PPE. Some staff wore face coverings rather than surgical masks increasing the risk they would catch and spread COVID-19.
- Records did not evidence that all staff had completed infection prevention and control (IPC) training. Not all staff were confident they had received training to safely put on and take off PPE, and were not able to demonstrate the appropriate method for using PPE.

We found no evidence people had been harmed, however, effective systems were not in place to assure us infection risks were managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- Staff recruitment processes were in place. However, we identified gaps within these systems.
- Some staff references did not indicate where they had been requested from. When references were unable to be secured, there was no evidence of any attempts to secure these from elsewhere, or records to show risks that had been encountered had been assessed.
- People were supported by a sufficient number of staff. They told us staff responded to them when they required support.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- During the inspection a number of concerns were made about the safety of some people living in the home. We asked the provider to investigate these and provide us with an outcome. We also raised a safeguarding alert with the local authority.
- Not all staff had completed safeguarding vulnerable adults training.
- Safeguarding concerns that had occurred since the last inspection had been appropriately responded to,

to ensure people were kept safe from abuse.
● People and relatives felt the service was safe. They told us staff "looked after" them.
● Where accidents and incidents had occurred, preventative actions were put in place to reduce the risk of repeated issues. Whilst there was analysis of incidents and accidents, this was not robust to look for any safety related themes.

Assessing risk, safety monitoring and management

At our last inspection, systems were not in place to ensure people's health needs were met. This placed people at risk of harm. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 9.

● Care plans contained explanations of the control measures for staff to follow to keep people safe, and support their healthcare needs.
● Staff understood where people required support to reduce the risk of avoidable harm.
● The work to update people's care plans and risk assessments to reflect their current needs was ongoing.

Using medicines safely

At our last inspection systems were either not in place or robust enough to ensure the proper and safe management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had been made and the provider was no longer in breach of this regulation in relation to the management of people's medicines

● Medicines were managed safely.
● Accurate records were completed in relation to the management of topical creams, and other prescribed medicines. Detailed protocols to guide staff how to support a person with administration of medicines 'as and when required' were now in place.
● The provider had implemented an effective system to identify any shortfalls in medicine practice in a timely manner.

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 Inadequate. At this inspection this key question has improved to requires improvement. 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.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

At our last inspection the provider had failed to operate effective systems to monitor the quality and safety of the service. We issued a warning notice for a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was a continued lack of provider oversight to ensure systems and processes in place were being operated effectively, and used to drive improvement.
- The provider had failed to ensure government guidelines for working safely in care homes during the COVID-19 pandemic were adhered to.
- Although quality monitoring checks had been completed in relation to infection prevention and control, and the environment, they had failed to identify risk, or areas of concern so that improvements could be made to practice.
- Practices we observed in the service did not reflect the providers own policies. For example, the rearrangement of communal areas to maintain social distance. The Infection Control policy did not contain any guidance on the management of Covid-19.
- Records did not reflect that staff had completed training required to carry out their role. Gaps in the training matrix identified the need for staff to complete, or update training including for infection prevention and control, moving and handling, fire safety, and safeguarding. The manager was in the process of securing attendance to these training courses for staff.

We found no evidence people had been harmed, however, systems were not robust enough to demonstrate effective oversight of the service. This placed people at risk of harm. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Some improvements had been made since the last inspection, and we saw there was an effective system in place to seek feedback from people and their relatives about their care and the service they received.
● The provider and manager had acted on people's feedback or concerns to drive improvements. For example, one person had raised a concern with the cooking of their food. There was a record of how this had been addressed.
● Staff felt listened to and supported. Comments included, "We have now got the management we needed. [Name] has fitted in well and pulled us all together" and "[Name] is approachable, one of the best bosses I have ever had, you can talk to them about anything."
● People's care records contained personalised information about their needs and preferences about how they wished to receive their care. A relative told us, "The manager sees the person behind it, not just the business side. It feels more like person-centred care."

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. Working in partnership with others
● The provider and manager were open, honest and responsive to issues and concerns raised at this inspection.
● People received support from external health care providers, where this was required to meet their needs. This included GPs and district nursing.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure there was a robust governance system in place. The checks, audits and systems in place did not effectively identify shortfalls. Regulation 17 (1)(2)(b)

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 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to ensure infection control practices were sufficient and adequately protected people from the risk of transmission of Covid-19 and other infectious diseases. Regulation 12 (1)(2)(h)

The enforcement action we took:

Urgent Notice of Decision to place conditions on the registered providers registration.