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

Summary of findings

Overall summary

This was an unannounced inspection which took place on the 10,11 and 12 October 2017.

Belmont Care Home provides residential care for up to 40 people. Since our last inspection in March 2017, the service has not accepted any new admissions to the home. During this inspection there were 19 people living at the home.

At our inspection in January 2017. We identified breaches of five of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which were in relation to good governance, safe care and treatment, premises, training and person centred care. We also identified two breaches of the Care Quality Commission (Registration) Regulations 2009 in relation to the provider not submitting statutory notifications as required. We rated the home 'Inadequate' and placed the service into special measures. We then completed a focussed inspection in March 2017 due to concerns we had received. We looked at areas in the safe and well-led sections. The service was again found to be inadequate in safe and well-led, with continued breaches 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 training and supervision.

Requirement notices were issued for all the breaches of regulations. In March 2017 a warning notice was issued for the breach of regulation 17 Good Governance. The provider sent us an action plan telling us how they would become compliant with the regulations.

During this inspection we checked if the required improvements had been made. We found the provider was still in breach of the regulations identified in our last two inspections of the service and we also found a further two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service remains 'Inadequate' and the service remains in special measures. We are currently considering our options in relation to enforcement in response to the breaches of regulations identified. We will update the section at the back of the inspection report once any enforcement work has concluded.

We also made one recommendation, that the service ensures toilet facilities have appropriate locks on them to ensure that people's privacy and dignity is maintained.

We found that not all windows were fitted with appropriate restrictors. This did not follow the Health and Safety Executive (HSE) published guidance on the use of window restrictors in care homes. Appropriate window restrictors prevent the windows in care homes from being opened too widely and people falling from the windows.

Health and safety checks and equipment maintenance checks were not completed. Areas of the building were not adequately maintained or secure. Records of fire safety checks were either not available or were

incomplete and did not show regular checks or testing had been carried out. Areas of concern identified in the last fire risk assessment had not been addressed.

Medicines were not managed safely. Staff were not provided with sufficient information about medicines that were to be given 'when required'. Records indicated that medicines storage temperatures were not being monitored and recorded to ensure medicines remained effective and no action had been taken to rectify this. There was little evidence to demonstrate that staffs continued competency to administer medicines had been checked and records of stocks of medicines could not be found.

Systems for the recruitment of staff were not sufficiently robust and did not ensure all required pre-employment checks had been made. Staff had not received the training, induction or supervision they needed to support them to carry out their roles effectively.

Some care records had been updated since our last inspection. We found the new care records to be person centred and gave detail about peoples likes and dislikes and the way they wanted to be supported. However we found that care records had not been reviewed regularly. Care records including risk assessments were not always accurate or had not been updated when people needs had changed. Records of support provided were not always complete.

The provider was not meeting the requirements of the Mental Capacity Act (MCA) 2005. People were potentially being unlawfully deprived of their liberty.

People we spoke with told us staff treated them with respect. However, we found that people's privacy and dignity was being compromised. We found that two toilet doors that opened onto public areas of the home did not have privacy locks on them. One of these toilets was directly opposite the front door. Had the toilet door been left open people using the toilet area would have been visible from the front door.

We observed staff interactions that were gentle, friendly and caring. Staff took their time when supporting people and no one was rushed. Staff knew people well.

There was a lack of planned activities for people to take part in. People told us they didn't go outside the home very often.

There was a lack of systems to monitor and improve the quality of the service. We found checks and audits that were carried out by staff within the home were incomplete and not sufficiently robust to ensure best practice was followed and compliance with regulations was being maintained.

The Care Quality Commission (CQC) asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. The completion of a PIR is a legal requirement of a provider's registration with the CQC. The provider did not return the information we requested.

The service is required to have a registered manager in place. 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 service did not have a registered manager.

The service are required to notify CQC of events such as accidents, serious incidents and safeguarding

allegations. The service had not notified CQC of all events they are required to.

Staff were positive about working for the service and the improvements that had been made since our last inspection.

The provider was displaying the rating of the last CQC inspection as they are required to do.

The overall rating for this service is 'Inadequate' and the service is in 'special measures'. 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.

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.

Buildings and equipment were not checked, maintained or secure. There was a lack of appropriate restrictors on some of the windows which was also identified at our last inspection. Records of fire safety checks were incomplete and action had not been taken to address risks identified in the last fire risk assessment.

Recruitment processes were not sufficiently robust to protect people from the risk of being cared for by unsuitable staff.

Medicines were not managed effectively.

We saw sufficient supplies of protective clothing such as disposable gloves and aprons were available.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had not received the induction, training and supervision they required to ensure they were able to carry out their roles effectively.

The provider was not meeting the requirements of the Mental Capacity Act 2005.

People told us they liked the food. However we found the kitchen to be unclean and records of kitchen food safety and hygiene were not complete.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always protected. Two toilet areas that opened onto public areas did not have locks on the doors.

People told us staff were caring and showed them respect.

Staff knew people well and we saw staff were gentle, friendly and caring in their approach.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care records had improved but care records including those relating to identified risk were not always complete, accurate or updated when people's needs changed.

There were not sufficient activities to keep people stimulated or encourage social interaction.

There was a suitable complaints procedure for people to voice their concerns. However records were not kept of complaints made or action taken.

Is the service well-led?

Inadequate

The service was not well-led.

The service did not have a registered manager.

The systems in place to assess, monitor and improve the quality and safety of the service provided were not sufficiently robust.

Notifications have not been made to CQC.

The provider had not completed and returned a Provider Information Return, which is a legal requirement.

Staff were positive about working for the service and told us they thought the service was improving.

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 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 was an unannounced comprehensive inspection which took place on the 10, 11 and 12 October 2017. On the 10 October the inspection was undertaken by three adult social care inspectors, a specialist advisor who was a pharmacist 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. This person had experience of services for older people and people living with dementia. On the 11 and 12 October the inspection was undertaken by two adult social care inspectors.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. The provider did not return the information we requested. We have addressed this in the well-led section of this report.

Prior to the inspection we had received information of concern relating to medicines administration which is subject to an ongoing investigation. We did not look at the specifics of that case but did look at some of the issues raised.

We reviewed information we held about the service and provider, including notifications the provider had sent us. A notification is information about important events which the provider is required to send us by law. We also asked the local authority and Healthwatch Stockport for their views on the service. Prior to our inspection Stockport Metropolitan Borough council (SMBC) shared an action plan they had implemented with Belmont Care Home in response to their identified concerns. We used this information to help us plan our inspection.

As some people living at Belmont Care Home were not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us

understand the experience of people who could not talk to us.

During our inspection we spoke with eight people who used the service, one visitor, the provider, the deputy manager, six care staff, the laundry assistant and the chef.

We carried out observations in public areas of the service. We looked at nine care records, a range of records relating to how the service was managed including medication records, five staff personnel files, staff training records, staff duty rotas, policies and procedures and quality assurance audits

Inadequate

Is the service safe?

Our findings

People who used the service told us they felt safe living at Belmont Care Home. One person told us, "You are not left on your own, [staff] always looking in on you and if you are not well they look after you." Another person said, "I feel safe; staff are very nice and they get the GP whenever it is necessary."

At our inspections in January and March 2017 we found that the premises were not always maintained securely to protect people from harm and people were not protected against the risk associated from unsafe or unsuitable premises. This was because appropriate window restrictors were not fitted and all the required maintenance checks had not been carried out. A requirement notice was issued.

During this inspection we looked to see if the required improvements had been made. We found the breach in regulation had not been met.

Following the inspection in January 2017 we were given assurances by the registered manager at the time that the appropriate window restrictors had been put in place. During our tour of the building at this inspection we found 13 windows with restrictors that did not meet the Health and Safety Executive (HSE) standards as they did not have tamper proof restrictors on. This did not follow the HSE published guidance on the use of window restrictors in care homes. The appropriate window restrictors prevent the windows in care homes from being opened too widely and prevent people falling from the windows. We found one bedroom on the first floor had full length glass doors that opened onto a balcony area on the first floor. There were no restrictors in place on these doors.

The provider confirmed to us that no one currently using the service was deemed to be at risk from falling through open windows. We sat with the deputy manager and showed them the HSE guidance on window restrictors, which provides advice on controlling risks from potentially unsafe windows. We also discussed this guidance with the provider. This was to ensure they knew what the guidance stated. As a result of our findings we requested an immediate audit of all windows to identify if restrictors were in place and whether they met HSE guidance. We then advised the provider that until all window restrictors met HSE guidance they should complete risk assessments for each of the none compliant windows until appropriate action had taken place. On the third day of our inspection we saw that some new windows locks had been fitted, these were fixed using non tamper proof screws and as a result, still did not meet the required standard.

We reviewed cleaning and food preparation records relating to the kitchen. Records of fridge temperature checks and cleaning schedules were not available. The kitchen was visibly dirty and areas of the kitchen were in need of repair so that they could be cleaned properly. The kitchen waste bin was rusty and could not be easily cleaned. During our inspection the environmental health service undertook an inspection. The deputy manager told us environmental health had identified areas of improvement that were needed and would be revisiting the service the week after our inspection.

We found there were no records kept of water temperature checks for any of the home's hot water supply since April 2017. An audit completed in April 2017 had identified that the water supply to the "small dining

room" was 62 oC. People who used the service had unsupervised access to this hot water tap and it therefore posed a risk of scalding. During our inspection we tested the water temperature from this tap and it reached the maximum temperature on the thermometer of 55oC. There was no record of any action having been taken and there was no risk assessment in place to show how the risk of people being scalded had been reduced. Water temperature checks are important because of the risk to people who use the service being scalded. This did not meet HSE guidance on managing the risks from hot water in health and social care facilities.

Whilst looking around the environment we identified serious concerns in relation to two fire exits, one situated in the ground floor dining room where the exit system linked to the fire alarms was broken and was being secured by locks that required use of both hands to open it. This door opened into an area that also gave access to the basement which was accessed by very steep stairs. There was a light weight chain on hooks that was the only restrictive system preventing people falling down the stairs. Another fire exit on the first floor landing was not secured and allowed people unsupervised access to the roof top terrace which posed a risk of people who used the service falling from heights. This terraced area could also be accessed via one of the bedrooms that was not in use but was not locked.

A fire risk assessment had been completed in May 2017 by an external company. It identified seven areas as high priority and in need of remedial action. There was no update or written evidence that these actions had been addressed, nor that the fire risk assessment had been kept under review. We asked the deputy manager if the work had been completed. They were unable to clarify if this had been completed. The report detailed that some of the fire protection (intumescence) strips on fire doors had been painted over and needed replacing. We saw that this had been discussed at a health and safety meeting at the service in May 2017. It had been recorded in the minutes that ' the felt strips on some communal downstairs doors needed to be replaced as the previous contract painter had painted over them so they would not be effective to hold in smoke should there be a fire'. During our inspection we found that these strips had not been replaced.

We were told the maintenance person was responsible for completing internal checks to the building helping to ensure the premises and facilities were safe to use. These included checks in relation to fire safety and the completion of fire drills which it was identified needed to be carried out on a quarterly basis.

We reviewed fire safety records. Records we looked at showed that only one fire drill had been carried out between May 2015 and the date of our inspection. This had only involved 10 members of staff. Fire drills should be carried out regularly to ensure staff and people who use the service are aware of action to take in the event of a fire. Training records showed that only 14 members of staff had undertaken fire safety training. One person who used the service told us they did not feel safe because they were uncertain what would happen if there was a fire and how they would get out of the building.

Records of fire safety checks were either not available or were incomplete and did not show regular checks or testing. Fire alarm tests did not detail weekly testing; there were no records of tests after May 2017. Fire fighting equipment had been tested by an external company but visual checks of extinguishers completed by the service had not been recorded since 29 June 2017. Emergency lighting was serviced by an external company but there was no evidence of testing by the service after May 2017. There were no records to show that fire safety door guards, that ensure doors close in the event of a fire, had been checked in 2017. During our inspection we found one door guard was beeping, which indicates a fault or that the battery is not working properly. This had not been identified by the service.

Regular checks of equipment required in the event of an emergency are needed to ensure it is functioning and suitable for use. Due to our concerns and the level of potential risk posed to people we contacted the

Greater Manchester Fire and Rescue Service to raise our concerns and share our findings. They inspected the service the day after our inspection, they have issued an enforcement notice and advised the service of action they are required to take.

We found this was a continued breach of Regulation 12 (1) (2) (a) (b) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider had not ensured the premises or equipment used were safe to use or used in safe way and had failed to ensure people were protected from the risk of harm or injury.

Following our inspection we asked the provider to send us an urgent action plan detailing how the areas relating to fire safety and building safety had been addressed. We received confirmation from the provider that windows restrictors were in place that met HSE guidance, work was underway to address all the issues in the fire risk assessment, a deep clean had been completed in the kitchen and external doors were secure.

At our inspections in January and March 2017 we found medicines were not managed safely. A requirement notice was issued. During this inspection we looked to see if the required improvements had been made. We found the breach in regulation had not been met.

We looked to see if people received their medicines safely. Our specialist advisor, who was a pharmacist, looked at the way medicines were stored, recorded and used in the home. We found that medicines were not managed safely.

We saw medicines management policies and procedures were in place to guide staff on the storage and administration of medicines. The policy did not provide detail of training, quality controls or assurance processes. We observed staff carrying out a medicines round and saw that safe practices were used.

We looked at fourteen peoples medicines administration records (MAR) during the inspection. We observed that each person had a MAR chart in place; this included a photograph of the person and detailed any allergies they had. It was not possible to review the ordering process and to ascertain checks and controls to ensure accuracy of the MAR record and patient needs, as this was now undertaken online and no records were available at the time of inspection. The deputy manager told us they did not know how to do this as the last manager did these checks. The deputy manager told us they had arranged for the supplying pharmacist to visit the service to show them and senior staff how this process was completed. There were no records of a process for identifying discrepancies within a person's MAR record. There was no evidence of the MAR being checked by the manager or senior staff to confirm MAR records were correct.

Some people were prescribed one or more medicines to be taken only 'when required' (PRN). PRN protocols were available for some people's medicines; however they were last reviewed in June 2017. There were several PRN medicines on the MAR sheets where protocols were not available. This meant there was a risk of 'when required' medicines not being used effectively or safely and that people may not get their medicines as prescribed. We also found that where PRN medicines were not required the N/ R code (not required) was not always used therefore the MAR record was not fully completed as required.

MAR sheets for topical application, such as creams, were removed from the MAR file and kept in a file in peoples rooms for care staff to complete. Topical application records were not complete and administration records not available for six residents who were prescribed topical medicines.

Due to the risk of choking one person was prescribed 'thickeners'. Thickeners' are added to drinks, and sometimes to food, for people who have difficulty swallowing. Fluid charts had been put in place to record

fluids people received but did not include the use of thickeners. Whilst staff we spoke with were aware of a person's needs, records seen did not clearly identify which thickener the person had been prescribed and the specific directions for use. This information is important particularly due to the number of agency staff currently used by the service to support people. It is also important that staff accurately record the use of thickener to ensure people are given their medicines safely, consistently and as prescribed. The deputy manager told us they would provide the appropriately detailed charts for the care staff to record when they had administered the prescribed thickeners.

We found that most medicines were stored securely and only authorised staff who were responsible for administering medicines had access to them. We found that prescribed topical medicines for one person were on a shelf in their bedroom visible and not locked away. On the first day of our inspection we noted that one person was prescribed a food supplement. We found this was stored in an unlocked fridge in a communal dining area. We discussed this with the deputy manager who immediately removed them to a secure area.

At the time of our inspection the service was not administering controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for their misuse). We noted that secure storage was available for this type of drug should it be needed.

We looked at the records for the storage temperature of the medicines for the last three months. We found that out of 71 days reviewed there were no recordings of medicines fridge temperatures for 17 days and no recordings of medicines room temperatures for 26 days. Storage temperature checks are important as they ensure medicines are being stored correctly and remain effective.

In the medicines fridge we found a urine sample dated September 2017. When we asked a senior staff member why this had not been sent for analysis or disposed of they did not know. They told us the person had left the service some time ago.

We looked to see what training staff had received to ensure they knew how to administer medicines safely. We found that one staff member responsible for administering medicines had not received any training for this task and another person's medicines training had last been completed in 2008. We were told that the last manager had completed competency assessments with all staff who were administering medicines. We found there were only records of three individual staff competency assessments in 2017. No records could be found to demonstrate that any other competency assessments had taken place.

This was a continued breach of Regulation 12 (2) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. Medicines were not managed safely.

The provider had a contingency plan, which provided information and relevant contact details for agencies such as utility companies should there be a loss of water supply, electricity or gas supplies or failures within the building, such as the lift breaking down. This contingency plan would help staff to ensure the continuity of service to people.

At our inspections in January and March 2017 we found the provider had not taken all reasonable and practicable steps to assess and reduce risks to people using the service. A requirement notice was issued. During this inspection we looked to see if the required improvements had been made. We found the breach in regulation had not been met.

We looked at how the service assessed, monitored and mitigated potential risks to people to help ensure

their health and well-being was maintained. We saw that risk assessments included pressure areas, nutrition and hydration, moving and handling, and falls. A review of nine people's records showed that appropriate action had not always been taken to help reduce or eliminate identified risks.

In one person's records there was information which indicated the person was at very high risk of developing pressure sores. An incident record dated 9 September 2017 had indicated that the person had developed a pressure sore. There care plan had not been updated to reflect this. The last change to the care plan had been in August 2017.

We found that one person was at high risk of falls. This person had experienced approximately seven falls over recent months. However there was no evidence of any action being taken to reduce the risk; such as a floor sensor to alert staff or referral to the falls co-ordinator. We visited this person in their bedroom we noted the flooring around their armchair was torn and posed a significant trip hazard. We raised this with the deputy manager who said they were aware of the issue and would need this to be addressed by maintenance staff. During our inspection the furniture in the bedroom was rearranged to cover the torn flooring. The deputy manager confirmed after our inspection that the flooring had been replaced.

Further concerns were identified in relation to a person's nutritional needs. An eating and drinking assessment had been completed and scored the person at very high risk. This guided staff to 'seek dietician advice'. A review of the person's records and discussion with the deputy manager identified this had not been done. Another person's eating and drinking assessment stated the person had a 'usual appetite'. However the care records identified this person needed encouragement to eat and had a poor appetite. Therefore the assessment was incorrectly scored reflecting the person was high risk. Again no advice had been sought from the dietician and a review of records showed their dietary intake was not monitored and reviewed.

Other examples showed that a risk assessment for someone self-medicating was vague and did not evidence checks were made to ensure medication was being taken. We found that risk assessments, particularly where people were assessed at high risk had not been kept under regular review to help ensure changing needs were clearly identified and monitored.

These shortfalls did not demonstrate people's health and well-being was protected. The provider had failed to ensure care and support was consistently provided in a safe way, and that adequate and proportionate actions to reduce risk were not always taken.

This was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014. The provider had not taken all reasonable and practicable steps to assess and reduce risks to people using the service.

At our inspection in January 2017 we found that recruitment procedures were not as robust as they should be and we made a recommendation that the provider review their processes for auditing and checking staff recruitment. During this inspection we found improvements had not been made.

We looked at five staff personnel files. It is a regulatory requirement that the provider should ensure that before people are employed, they have the person's full employment history and a satisfactory written explanation of any gaps in their employment. None of the files we looked at contained a full employment history or a written explanation of gaps in employment. We found three of the files had gaps in employment that covered long periods of time and two other files did not contain any employment history. The pages of the application form that should contain this information were not in those two personnel files and the

deputy manager was not able to locate them.

We found four of the staff personnel files contained appropriate references from their previous employer(s); however one file only contained one reference.

Four of the personnel files we reviewed contained a completed check with the Disclosure and Barring Service (DBS); the DBS identifies people who are barred from working with vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. One file did not contain a completed check with DBS and the provider confirmed that the DBS check had not been completed prior to the staff member being employed. Prior to our inspection in September 2017 we had been contacted by the service to ask about recruitment procedures and if they could start one staff member without a DBS check and another staff member with only one reference. We had informed the service that if they started a staff member without appropriate checks they would be in breach of regulations. We noted during our inspection that the two staff referred to had started to work at the service without the required checks being made.

This was a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The safety of people who used the service was placed at risk as the recruitment system was not robust enough to protect them from being cared for by unsuitable staff.

We looked to see if arrangements were in place for safeguarding people who used the service from abuse. We found policies and procedures for safeguarding people from harm were in place. These provided staff with guidance on identifying and responding to signs and allegations of abuse. Training records we looked at and staff we spoke with confirmed 11 staff had received training in safeguarding. Staff were able to tell us the potential signs of abuse, what they would do if they suspected abuse and who they would report it to. We saw that the service had a whistleblowing policy. This told staff how they would be supported if they reported poor practice or other issues of concern. Staff we spoke with told us they were confident they would be listened to and that any issues they raised would be dealt with promptly. The service had not always notified the Care Quality Commission (CQC) when safeguarding issues were raised. We have dealt with this in the well-led section of this report

We asked the deputy manager how staffing levels in the home were determined. The service did not have a dependency needs assessment. There were 19 residents living at the home at the time of our inspection. The deputy manager told us that staffing levels were based on these people's needs. They told us that the service was trying to recruit more permanent staff but whilst they were doing this they did use agency staff to fill vacant hours.

Staff told us they felt there were not always enough staff but told us they hoped this would improve as new staff were being recruited. One staff member said," There are not enough staff but we are waiting for DBS for some", "They [managers] are still recruiting." We saw that regular agency staff were used. We were told this was to help ensure continuity of care as people knew the regular agency staff. Duty rotas we looked at showed that staffing was usually provided at the level the deputy manager had told us. People who used the service gave us mixed opinions on staffing levels. They told us, "There is a staffing problem, not enough staff. If two more carers were on this shift [afternoon] it would make a lot of difference; I wouldn't have to wait so long", "As far as I know there is enough staff; you don't have to wait long for someone" and "Not really, they are run off their feet, but it's not long to wait when I ask for assistance". During our inspection we observed that staff responded quickly to requests for assistance when call bells were sounded and there were sufficient staff to meet people's needs.

We looked at what arrangements were in place to manage and control the spread of infection. We saw

sufficient supplies of protective clothing, such as; disposable gloves and aprons were available. Staff were seen to wear them when carrying out personal care duties or assisting at meal time. Liquid soap and paper towels were available in areas where personal care was provided. We also saw yellow 'tiger' bags were used for the management of clinical waste.

We saw that designated domestic staff were available each day and records were maintained to demonstrate the areas of cleaning completed. Whilst looking around the home we found bedrooms and communal areas were clean and free of malodour. People we spoke with told us the home was always clean. One person told us, "The home is clean definitely, the bedding and everything." We did however note that up to date policies and procedures were not in place to guide staff. There were also no periodic checks undertaken to ensure hygiene standards were maintained. We have addressed this in the well-led section of this report.

We looked at the systems in place for maintaining the laundry service. The service had a system for keeping dirty and clean items separate and used red alginate bags to safely wash soiled items. Soiled items can be placed in these bags which then dissolve when put in the washing machine. This helps prevent the risk of spread of infection or disease.

The service had an incident and accident reporting policy to guide staff on the action to take following an accident or incident. Records we looked at showed that accidents and incidents were recorded. The records included a description of the incident and any injury, action taken by staff or managers.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us the service provided them with the care and support they needed. A visitor told us there relative who used the service was, "…Assisted to move about, eat and receives medical attention as and when required."

At our inspections in January and March 2017 we found staff had not received sufficient training and support they needed to carry out their roles effectively. During this inspection we looked to see if the required improvements had been made. We found the breach in regulation had not been met.

Records we looked at showed that when staff started to work at the service they received an induction. This included shadowing experienced staff and being given information about the service, health and safety and important policies and procedures. The deputy manager told us that the service did not complete the care standards certificate. The Care Certificate is a standardised approach to training for new staff working in health and social care. We saw completed induction checklists but staff did not complete all mandatory training during their inductions. One member of staff we spoke with told us they did not feel they had received enough training before they started working in their role. They said; "I had one day's moving and handling before I started and I don't think it's enough." Another said "I was supposed to be shadowing [when they started working at the home] but I was left on my own."

Most staff told us that they felt supported and could go to the person in charge if they had any problems. We saw that since our last inspection in March 2017 some improvement had been made and staff supervision had taken place. All staff had received one supervision session since our last inspection and seven staff had received two supervisions. However staff had not received supervision in line withas stated in the provider's quality assurance policy, which states that staff will receive supervisions at two monthly intervals. Supervision is important as it provides the opportunity for staff to review their performance, set priorities and objectives in line with the service's objectives and needs and identifies training and continual development needs.

One staff member we spoke with told us they had had lots of training. However training records showed that since our last inspection there had been little improvement in staff training. Of the 17 permanent staff providing care, four had received training in infection control, three in dementia awareness, eight in the Mental Capacity Act and Deprivation of Liberty Safeguards and only nine in manual handling and health and safety. This meant not all staff had received the training they needed to carry out their roles effectively.

This meant there was a continued breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that staff received appropriate training and support.

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. Where people lack the mental

capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

During this inspection we checked to see if the service was working within the principles of the MCA. We saw information to show that six applications had been made to the supervisory body (local authority) for those people still living at the home. We found one had been authorised, one was subject to review and a decision in relation to the remaining four had yet to be made. We asked the deputy manager if further applications had been made, where it had been assessed people may be deprived of their liberty. They were not able to provide any further information.

A review of care records for nine people showed that a two part capacity form was completed. On part one the assessor was asked if the person lacked the mental capacity to make decisions for themselves. However we found no capacity assessment had been completed. Assessments on part one and two of the form identified the level of cognitive impairment for that person. We saw on five of the forms the person had been rated as having a moderate or severe impairment. These scores directed staff to consider or make an application for a DoLS. However when asked if a DoLS application was required this had been answered 'no'. There was no further information to explain how or why this decision had been made.

We saw these assessments had been completed by two senior care staff. A review of their training records showed they had not completed any training in the MCA and DoLS. As these staff were not available during the inspection we were unable to establish their understanding of the MCA and DoLS procedures.

This meant there was a breach in Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

We saw that information was available to guide staff on the MCA and DoLS procedures. However this information did not reflect current legislation. The deputy manager told us that the homes policies and procedures were current under review. Copies of the new policies were seen however we were told that these had yet to be shared with staff.

We reviewed training records and spoke with care staff to check their understanding of the procedures. Staff were not able to demonstrate their understanding of the MCA principles and DoLS procedures. Records showed that training in these areas had not been completed by all care staff. This training is important and should help staff understand that where a person lacks the mental capacity and is deprived of their liberty, they will need special protection to make sure their rights are safeguarded.

We looked at how people were involved and consulted with about their care and support. The deputy manager said they were in the process of implementing a new care plan format. A review of the new plans showed these had been written in the first person and detailed their wishes and feelings. We saw that, where appropriate, relatives had also been consulted with about their family member. We found that some people had an 'attorney' who was lawfully able to act on their behalf in relation to finances and /or health and welfare decisions. A copy of the authorisation was held on the person's file.

During our inspection we observed a lunch time meal. The dining room was pleasant and there was sufficient space between the tables to allow for people using walking frames and wheelchairs. Each table had a table cloth, condiments, napkins and cutlery.

We observed staff sat at the tables to assist three people who needed support with their meal. No one was rushed and the atmosphere was calm. One person was not eating or drinking much at all and was very sleepy. A member of staff said that they would take the person to their room for bed rest.

We spoke with one person who used the service. They had recently drunk a cup of tea and had eaten a cake which was the mid-morning snack; they told us that they had the same again in the afternoon. They told us they had breakfast in their room, lunch and tea in the dining room. The person said; "The food is quite adequate, I am happy with it." Other people we spoke with described the food as, "Lovely, very good" and "The food is average; there is an alternative if I don't like what is on the menu." Another person who used the service said, "The foods good; I have breakfast in my room, cornflakes and toast; this [lunch] is my favourite meal. There are mid-morning and mid-afternoon snacks of a drink and a cake with a drink and a biscuit at supper time which is enough as we have good meals during the day." People told us that there was a choice and that they were offered an alternative if they didn't like what was on offer.

Throughout our inspection we saw that people were regularly offered drinks and snacks in between meals.

Records we looked at showed that people had access to a range of health care professionals including, community psychiatric nurses, psychiatrist, dentist and diabetic specialist nurse. The General Practitioner (GP) visited every week, staff could ask the GP to see someone if there were issues and people could ask to see the GP if they wished. District nurses also visited the service twice every week. People who used the service told us the GP was always called whenever needed and a visitor we spoke with told us they were always informed if their relative needed to see the GP.

Requires Improvement

Is the service caring?

Our findings

People who used the service we spoke with said, "It is ok; the girls [staff] are all friendly, kind and caring", "I am quite happy here; I have got used to it", "…quite settled here" and "I don't want to say anything disrespectful but it's not like home is it?" Other people told us, "The staff are very good, can't grumble about the staff", "The staff's alright." One person told us "I am alright here; I get on with the staff ok." Another person said that there were often staff changes, they told us, "You get used to one [staff] then off again."

During our inspection we found that two toilet areas on the ground floor did not have privacy locks on, therefore anyone using the toilet could not lock the door to prevent someone from walking in. One of these toilets was directly opposite the front door. Had the toilet door been left open people using the toilet area would have been visible from the front door. This meant that people's privacy and dignity could not be protected. We discussed this with the deputy manager who said they would arrange for locks to be fitted to the two doors immediately. We recommend the provider ensures all toilets and bathrooms have appropriate door locks fitted to ensure people's privacy and dignity is protected.

People we spoke with told us staff treated them with respect. One person who used the service said, "[staff member] is lovely, she looks after me well, gives me a bed bath and just pops in to see me as soon as she starts her shift."

One person who used the service told us that at night there are two staff on duty one of which is sometimes a man. They were not happy about this. They told us they did not like a man changing their continence pad which sometimes they had had to do. We discussed this with the deputy manager who said that whilst sometimes there were male staff on duty, arrangements had been made to ensure that the male staff supported other staff when manual handling was needed but then left the room whilst the person was changed. This meant that the servicie had looked for wasys to respect the persons wishes.

We spent time observing the care provided in communal areas of the home. We saw staff interactions were gentle and staff spoke with people whilst helping them with personal care. We saw staff interacting with people in a friendly, caring and understanding manner. No one was rushed. Staff regularly encouraged people to drink.

Staff told us they knew the service users well and would identify quickly if they were feeling unwell. They said; "The residents are great, they are really lovely." Another member of staff said; "I love my clients that's why I can never leave. I like it when they smile when they see my face."

We were told that visitors were welcomed to the home and that staff encouraged people to keep in touch with friends and relatives. One visitor told us they were always made to feel welcome when they visited.

Care records we looked at contained information about peoples wishes about how they wanted to be cared for at the end of their lives. One person's file included details of the funeral arrangements they would like including them music they would like.

We found that records were stored securely. Policies and procedures we looked at showed the service placed importance on protecting people's confidential information.

Requires Improvement

Is the service responsive?

Our findings

At our inspections in January 2017 we found the provider had not ensured that adequate assessment and review of people's needs had taken place. A requirement notice was issued. During this inspection we looked to see if the required improvements had been made. We found the breach in regulation had not been met.

Since our inspection in March 2017 the service had not accepted any new admissions to the home to. They planned to do this until the required improvements had been made. Therefore the admissions assessment process was not reviewed during this inspection.

We looked at the care records for nine people to see how their needs were assessed and planned for. We found on one file the care plan had been completed on admission in 2016 but had not been kept up to date to reflect the person's current and changing needs. The deputy manager told us they had spent the last few months updating people's care records. On the new files we looked at, information was person centred and provided clear direction for staff. Plans included information about people's social, emotional and physical needs as well their individual wishes and preferences.

However we noted that monthly reviews of plans had not been completed in any of the files we looked at, as per the home's procedure.

This was a continued breach of Regulation 9 (1) (3) HSCA RA Regulations 2014 Person-centred care. The provider had not ensured that adequate assessment and review of people's needs had taken place.

One staff member we spoke with told us the new files made supporting people easier. They told us, "The new documentation had made a big difference."

At our inspections in January 2017 we found accurate and complete records of care were not consistently maintained. A requirement notice was issued. During this inspection we looked to see if the required improvements had been made. We found the breach in regulation had not been met.

Additional monitoring records were put in place to evidence the care and support provided where people needed specific support. This included hourly night checks, bathing and repositioning charts for people at risk of developing pressure sores and food and fluid charts for those at risk of poor nutrition. We found the monitoring records did not always support that care had been provided as identified in care plans and risk assessments.

Two people who used the service had been identified as at high risk of developing pressure sores. Their care records indicated they should be repositioned every two hours to help maintain their skin integrity. Repositioning charts we saw for both people indicated that in the two weeks before our inspection on a number of occasions repositioning had not occurred two hourly. We noted that neither person had developed pressure sores during this time.

Two peoples records identified they were at high risk of malnutrition and developing pressure sores. Their care records indicated the amount of fluid they needed to have each day. We reviewed the fluid intake charts for the week before our inspection. We found that the records indicated that the people had not received the amount of fluid their care records indicated they should receive. The charts and care records did not indicate that any action had been taken to identify if people had received the care and support they need or indicate that that any action had been taken to ensure support identified in care records was provided We noted that during this time neither person had lost weight or developed pressure sores.

Accurate information is important to demonstrate people have received appropriate care and support to meet their individual needs.

This was a continued breach of Regulation 17 (2) HSCA RA Regulations 2014 Good governance. Accurate, complete records of care were not consistently maintained.

At our inspections in January 2017 we found the provider had not ensured care was designed to meet service users' needs. A requirement notice was issued. During this inspection we looked to see if the required improvements had been made. We found the breach in regulation had not been met.

We looked to see what activities were offered to people that lived at Belmont Care Home.
People we spoke with told us that there wasn't always enough to do at the home. One person told us they did not go out of the home very often. People said, "…Not enough staff to take you out", "I miss going out, I don't get out at all; I would like to go out for a 'walk'." Another person told us they could play dominos but they felt; "enclosed….There is not enough to do". One person who used the service said "There are activities if you want to take part in them; entertainers do visit but I am not sure how often".

The provider told us that since our last inspection they had appointed an activities coordinator who had recently left the service. They told us they did not have a programme of activities but that staff offered activities to people. We saw that a specialist team had attended the service fortnightly to provide activities for people living with dementia. We were told that a recent activity was based on the television show 'Name That Tune' and had resulted in some service users dancing or singing along to the music. The deputy manager told us The Dementia team's visits were due to stop shortly and so the senior care worker had devised some similar activities to keep service users engaged. They told us that an entertainer visited the service regularly. During the three days of our inspection there were no organised activities on offer to people who used the service. Activities are important to promote peoples social interaction, movement and wellbeing and prevent social isolation.

This was a continued breach of Regulation 9 (1) (3) HSCA RA Regulations 2014 Person-centred Care. The provider had not ensured care was designed to meet service users' needs.

We looked to see how the service dealt with complaints. We found the service had a policy and procedure which told people how they could complain and what the service would do about their complaint. It also gave contact details for other organisations that could be contacted if people were not happy with how a complaint had been dealt with. People who used the service told us they could raise any concerns they had. They said, "I have no complaints or anything", "I would tell one of the girls [staff] or the bosses if I was not happy with anything" and "I have never complained about anything because I have had nothing to complain about". One person said, "I would go to [deputy manager] or [manager] who are very empathetic."

We asked the deputy manager to show us records of complaints and how they had been responded to. They were only able to find a copy of one complaint and this did not provide information on how the complaint

had been dealt with. Prior to our inspection we were aware of another complaint that the service had dealt with to the person's satisfaction. There was no record available at the service of this complaint. We have addressed this lack of records in the well-led section of this report.

Inadequate

Is the service well-led?

Our findings

At our last inspections in January and March 2017 we found there was a lack of robust systems in place to monitor the quality of service people received. A warning notice was issued following our inspection in March 2017. During this inspection we looked to see if the required improvements had been made. We found the breach in regulation had not been met.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help registered providers to assess the safety and quality of their services. This ensures they provide people with a good service and meet appropriate quality standards and legal obligations.

We requested records for quality assurance and governance since our last inspection in March 2017. There was little evidence of any checks or audits being completed. Systems in place had failed to identify or address the concerns we found during this inspection.

There were no records available to demonstrate there was a system of on-going weekly and monthly audits. One medication risk assessment/ audit dated 22 September 2017 identified that storage temperatures were not being taken; there was no record of action being taken. There were no records of stock checks of medicines. Fire safety and health and safety checks had not been completed and where issues had been identified no action had been taken to resolve issues. The building was not secured appropriately and appropriate window restrictors had not been put in place, there was no infection control auditing, the kitchen was in a dirty and poorly maintained condition and risks to individuals were not assessed appropriately. Care records were not all up to date and where new records had been put in place there was no evidence of regular review to ensure they accurately reflected peoples support needs.

At our inspection in January 2017 we found that recruitment procedures were not as robust as they should be and we made a recommendation that the provider review their processes for auditing and checking staff recruitment. At this inspection we found staff had started to work at the service without the required checks being made, as reported on in the Safe domain of this report.

There was no auditing of safeguarding's, complaints and accident and incidents. This meant that there was no analysis to look for areas of improvement.

We found this was a continued breach of regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems were not in place to assess, monitor and improve the quality and safety of the service provided.

Providers are required to notify CQC of certain significant events that occur within their services, including deaths, serious injuries, safeguarding incidents and DoLS authorisations. During the inspection in January we found that the provider had not notified CQC of eight incidents that required notifications. A requirement notice was issued and a fixed penalty notice was issued. During this inspection we found that the required

improvement had not been made and there had been further breaches of regulation.

Since our last inspection in March 2017 we found that the service had failed to notify CQC of four incidents where the police had been called and two safeguarding's incidents that had occured. This meant we were unable to see if appropriate action had been taken by the service to ensure people were kept safe. We noted that at the time of all the incidents the service had notified the local authority but had failed to notify CQC as is required.

We found this was a continued breach of Regulation 18 (2) (e) (f) of the Care Quality Commission (Registration) Regulations 2009. Failure to notify other incidents

It is a requirement that the service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service did not have a registered manager. The previous registered manager had left the service in April 2017. A new manager had been appointed in April 2017 and had indicated they were going to apply to register with CQC. They had resigned the day before our inspection and were not available during our inspection. The provider told us that whilst note permanent arrangements were put in place the day to day management of the service was going to be carried out by the deputy manager.

People spoke positively about the deputy manager. One person we spoke with told us, "[Deputy manager] is very good, does a good job". Another person said that since the last manager and the deputy manager had started at the service it had improved and they said they thought the service was; "now getting good staff." A visitor told us, "General health and well-being has improved. [Deputy manager] is a breath of fresh air; [person who used the service] loves him 'to bits'; he is very hands on."

Staff told us they felt staff and managers in the home had been trying hard to improve and that progress was being made. One staff member said; "I've worked in another nursing home and this is much better. People are trying hard to improve." Others staff said, "[deputy manager] is very approachable", "I like the atmosphere, staff are really great. I think we are getting there" and "people are trying hard to improve."

We saw the service had a range of policies and procedures to guide staff. We were told that the manager had been in the process of updating all policies and procedures. We found that some policies contained out of date information and or had been updated but not shared with staff. These included, infection control, medicines and MCA and DoLS.

Before our inspection we had asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. The provider did not return the information we requested. Prior to our inspection the last manager contacted CQC in September 2017 and told us they could not submit the information as the form had been sent to the previous registered manager. We advised the manager to send the information via email to the inspector for the service. We had not received this information by the first day of our inspection.

We found this was a breach regulation 17 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider failed to provide a written report on how the regulations were being complied with and plans they had for improving the standard of service provided.

We saw there was a service user guide and statement of purpose which had recently been updated. These documents gave people who used the service and professionals the details of the services and facilities provided at this care home. This should help to ensure people know what to expect from the service.

We looked at what opportunities were made available for people who used the service and their visitors to comment on the service provided. A visitor we spoke with said they had not been asked about the service and a service user said that no one had asked for their views and opinions and that they had not had a questionnaire that they could remember. We saw that earlier in 2017 a satisfaction survey about the food provided had been sent to 16 people who used the service. We saw that overall people were very positive regarding the food provided and people felt they got enough food and choices.

It is a requirement that CQC inspection ratings are displayed. The provider had displayed the CQC rating and report from the last inspection on their website and in the entrance hall of the home.