Vitality Care Homes Ltd

Belgrave Court Residential Care Home

Inspection report

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17 September 2020

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Ratings

Overall rating for this service	Inadequate

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

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 26 people using the service.

People's experience of using this service and what we found
People living at Belgrave Court did not receive a safe, caring or well-led service. There continued to be shortfalls with the management of people's medicines and governance systems.

People were at increased risk of experiencing harm, accurate records regarding medicines and prescribed creams were not always maintained. Care plans and risk assessments did not contain up to date and accurate information to inform staff how to provide safe care to people in relation to their medicine needs. People were not always supported in line with their individual needs.

The management and oversight of the service was still not robust enough to identify areas of concern and put actions in place to continuously improve quality and safety. This was the second inspection where the provider had not achieved a rating of good.

The registered manager made sure they alerted the appropriate authorities if there were allegations of abuse. Shortfalls in recruitment practices had been addressed and people could be assured new staff were asked to provide the robust information needed to make sure they were suitable for their role providing care and support to people. Staffing levels were adequate to meet people's needs.

Improvements had been made to the environment. The service was clean, pleasant and well maintained. Infection control practice in relation to the latest COVID-19 government guidance for the use of PPE in care homes was followed to keep people and staff safe.

We observed people were relaxed in the company of staff; and staff had some time to spend with people. Improvements had been made and privacy and dignity were respected.

Staff had received some individual supervisions and the registered manager held staff meetings to keep staff up to date. People told us the culture of the service was improving.

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

Rating at last inspection
The last rating for this service was requires improvement (published 12 November 2019) there were five breaches of regulations. 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.

Why we inspected
We carried out an announced comprehensive inspection of this service on 29 August, 04, and 06 September 2019. Five 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 compliance with dignity and respect, safe care and treatment, premises and equipment, good governance, and fit and proper persons employed.

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, caring and well-led which contain those requirements. We have found evidence that the provider needs to make improvement. Please see the safe, caring and well-led sections of this report.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

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 Requires Improvement to Inadequate. 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 Residential Care Home 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 safe care and treatment, person centred care, and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

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.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not 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.

Inspection team
The inspection was completed by four inspectors 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. On 27 August 2020 two inspectors visited the service. An Expert by Experience worked off site making phone calls to people's relatives. On 01 September 2020 one inspector visited the service to look at medicines systems; and on 17 September 2020 one inspector visited the service to review further evidence.

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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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 ten people living at the home and 13 relatives about their experience of the care provided. We spoke with two members of kitchen staff, the registered manager and provider.

We reviewed a range of records. This included four people's care records in part and nine people's medication records and medication audits. We also looked at staff meeting records, supervision and quality assurance records.

After the inspection
We continued to seek clarification from the registered manager and provider to validate evidence found. We viewed the records and additional information we requested sent to us via email and held further discussions with the registered manager and provider. We spoke with seven further members of staff and three professionals. We looked at several staff files in relation to recruitment, and records relating to the management of the service, including policies and procedures. We shared our findings with other professionals, so they were aware of risks at the home and the safety concerns we identified.

Inadequate

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely; Learning lessons when things go wrong

At our last inspection the provider had failed to take all reasonable steps to manage risk, and to manage medicines safely. This was a breach of regulation 12 (Safe care and treatment) 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 12

- People continued to be put at risk from unsafe medicines management. We found widespread shortfalls in the management of people's medicines.
- We could not be sure people had received their treatment as prescribed. Accurate records were not completed in relation to the management of topical creams, and other prescribed medicines placing people at risk. For example, one person was prescribed a topical cream to be applied two to three times daily. There was no record of where on the person's body this cream should be applied. Another person had a topical cream prescribed in July 2020. No records could be located for the application of this cream.
- Protocols to guide staff how to support a person with administration of medicines 'as and when required' were not always in place. One person was prescribed an inhaler. There were no instructions for staff to follow for administering this treatment.
- The provider had failed to have the oversight to ensure lessons were learnt and to sufficiently improve practice in order to keep people safe following our previous inspections.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Information about healthcare risks to people were not always appropriately recorded. For example, there was no guidance in place for staff about the signs and symptoms of potential health issues that could arise from diabetes for one person.
- Records available did not always evidence people had received treatment that met their needs and was in line with the healthcare professional's instruction. One person's skin integrity plan recorded a soap substitute prescribed should be used during personal care following incontinence. We noted 27 periods of

incontinence in August 2020. The corresponding medicine record for the same dates showed no recorded applications of the cream.
● Five bedrooms and one bathroom had single paned glass windows.

We found no evidence that people had been harmed however, systems were either not in place or robust enough 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.

The provider responded immediately during and after the inspection to the risks to people from single paned glass . They relocated people to other rooms to mitigate the risk; and instructed external contractors to fit double glazed panels.

Systems and processes to safeguard people from the risk of abuse
● During the inspection allegations of neglect were shared with us regarding three people living at 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.
● People told us they felt safe. Comments included, "Staff are protecting us." A relative told us, "Overall, I'm happy with the changes and [Name of person] care. I feel they are safe."
● Safeguarding concerns were appropriately responded to, to ensure people were kept safe from abuse and ill-treatment.
● The registered manager and staff we spoke to were able to demonstrate their knowledge of recognising potential abuse, and the action they would take if they believed people to be at risk. Staff told us they had received training on safeguarding adults. Comments included, "I have done training lots of times. I would report any concerns to the management and if nothing was done, I would go to CQC."

Preventing and controlling infection

At our last inspection the provider had failed to ensure that the premises and equipment used to deliver care were properly maintained and standards of hygiene appropriate for the purposes for which they were being used. This was a breach of regulation 15 (Premises and equipment) 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 15.

● Improvements had been made to the maintenance and cleanliness of the premises. The laundry area had been refurbished and there was a clear workflow to ensure clean linen was not at risk of contamination. Carpets and flooring had been replaced, and furniture and equipment was clean.
● One member of staff told us, "It's [cleanliness] a lot better now. One of the big things is the laundry. It's made a big difference the changes that have been made to that." A relative said, "It's freshly decorated. The dining room is like a restaurant. Communal areas are lovely. I'm so impressed and I have high standards."
● Staff were able to describe a range of additional infection control practices they followed due to the pandemic. Comments included, "We now have to wear masks. Make sure we constantly wash hands and using alcohol gel. We wear gloves where appropriate." A relative told us, ""The staff are always wearing PPE, the hand gel is always full."
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Staffing and recruitment

At the last inspection the provider had failed to ensure effective recruitment and selection procedures for suitable staff. This was a breach of regulation 19 (Fit and proper persons employed) 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 19

● People were protected from being cared for by unsuitable staff as the required pre-employment checks were carried out before new staff started work.
● A member of staff confirmed recruitment checks were undertaken prior to them commencing work at the home. They told us, "I had to wait two weeks for my DBS and a references to come through (before I started)."
● Staff were seen to be appropriately deployed to care for people.
● Most people living at the home, their relatives, and staff felt staffing levels were good. One person told us, "Staff are helpful. I can get up when I want to." A relative said, "During the day there seems enough staff. They are fairly busy. At one point there was a lot of agency staff used, but that's improved." During our visit, we saw staff were often on hand to respond promptly to people's needs.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

At the last inspection people were not treated with respect and their dignity was not promoted. This was a breach of regulation 10 (Dignity and respect) 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 10

● People's privacy and dignity was respected. Staff approach was observed to be respectful and patient. People told us, "I am a person and I get treated with respect. We are old people, we don't get treated as old, we get treated as a person" and "We get on here and get on with the staff. They treat us with respect." A relative said, "[Name of person] has to be moved using a hoist but staff are good at maintaining dignity."
● People were relaxed in the company of staff; and staff had some time to spend with people.
● People's records were stored securely.

Ensuring people are well treated and supported; respecting equality and diversity
● Systems and processes did not always ensure people were treated well and supported to receive treatment they required to meet their needs. One person was prescribed pain relief gel. One entry in their care records stated, '[Name of person] has been unsettled with pain in their knees.' There was no evidence the gel was applied to alleviate pain for the person.
● Two entries in another person's records showed they had complained of soreness/itching. They were prescribed treatment for this but was no evidence the treatment had been administered on the dates the person needed it.
● People told us they thought staff were caring and were happy with the staff and the service. One said, "They bend over backwards for us."
● We spoke with people's relatives who told us they thought the service was caring and focused on people. Comments included, "I can't fault them, staff are friendly, helpful and caring. [Name of person] seems to be very content" and "When I see [Name of person] they are always wearing clean clothes, hair too is lovely. They are bothered about [Name of person] appearance."
● We observed staff were caring towards people and saw some positive interactions between staff and people. For example, during lunch one person who required support to eat was given this discreetly and at their own pace.

Supporting people to express their views and be involved in making decisions about their care

● It was unclear from electronic care records if people had been involved in creating their care plans. Several relatives we spoke with gave us mixed views about their involvement. Comments included, "I don't think I've been involved in a care plan" and "I haven't been involved in a care plan at all. I am [Name of person] main carer and have power of attorney." Another relative told us, "They didn't just take the previous homes care plan, they spoke to me about [Name of person] care needs and listened to me about that."

● The registered manager and provider gave us verbal examples of people being consulted about changes to the home's decoration and food menus. One person was unable to recall being asked about the newly decorated areas. They told us, "I do like the décor." Another person said, "I don't get told what to do, I get asked. You can say no. We get a choice."

● We saw no evidence of any discussions or meetings with people to seek views about their care.

Inadequate

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 remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At the last inspection the provider had failed to operate effective and robust systems to monitor the quality and safety of the service. This was 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

- The service was not well led. Since the last inspection the registered manager and provider had implemented systems to review the quality of the service. Despite this, there continued to be shortfalls in the service and legal requirements were not always met.
- Governance systems in place had not identified significant issues with the management of people's medicines.
- Some information in care records was contradictory and incomplete. One person had two records in place which contained different allergies to medicines on both.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate they were effectively managed. This placed people at risk of harm. This is a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The service was not person-centred. People did not always receive treatment they required to meet their needs; and people were placed at risk of harm from unsafe medicine practice.
- There was no evidence of involvement or input from people around their care.
- We saw no systems in place to obtain feedback from people, their representatives or other stakeholders about the running of the service. The registered manager told us they had held discussions with people's relatives over the telephone during the pandemic. No surveys had been sent out since the last inspection and no other means had been used to gather opinions about what people would like to see improved or

changed.
● Relatives had mixed views about the quality of service their loved ones received. Several family members described having "No contact at all" during the pandemic, whilst others gave positive comments including, "The manager has been brilliant at keeping me informed."
● Where relatives had been able to visit the service more recently, they shared with us a sense of improvement. One told us, "What can I say about the place, it's amazing." Another said, "There have been lots of improvements. I feel since [Name of registered manager] has been there things have got better and better."

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 culture of the service was not always open and honest. During the inspection process we were provided with two differing records in relation to one person's medicine administration; we could not be sure of the accuracy of these records and which one was correct.
● Overall people and their relatives fed back positively about the management team. Comments included, "When I was there the last time, I had a brief chat with the assistant manager; who was very helpful." A member of staff told us, "Since the new manager took over it is so much better; and a nicer environment."
● Notifications had been sent to the CQC where it was appropriate to do so since the last inspection in August 2019.
● The registered manager and staff worked with external organisations that regularly supported the service.

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 9 HSCA RA Regulations 2014 Person-centred care The registered person had failed to provide people with person centred care and treatment that was appropriate to meet peoples individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to ensure people who use services were protected against the risks associated with unsafe care and treatment. There had been a failure to ensure the proper and safe management of medicines.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to implement adequate systems to continually assess, monitor and improve the quality and safety of the services provided.

The enforcement action we took:

We issued a Warning Notice