

Belle Rose Nursing Home Limited

# Belle Rose Nursing Home Limited

## Inspection report

12 Prince of Wales Road  
Dorchester  
Dorset  
DT1 1PW

Tel: 01305265787

Date of inspection visit:  
02 February 2021  
03 February 2021

Date of publication:  
13 April 2021

## Ratings

Overall rating for this service

Inspected but not rated

Is the service safe?

**Inspected but not rated**

# Summary of findings

## Overall summary

### About the service

Belle Rose Nursing Home provides accommodation, nursing care and support for up to 11 people with severe and enduring mental health conditions. There were ten people living in the home when we visited. The service is located in the centre of Dorchester and provides accommodation over two floors with a lift to access the bedrooms on the first floor. There are communal living and dining areas and a garden to the rear of the property.

### People's experience of using this service and what we found

Improvements had been made at the home following advice from the Dorset NHS Clinical Commissioning Group (CCG) Quality Improvement Team. For example, equipment such as bins had been replaced to reduce cross infection risks and we saw that staff were correctly using personal protective equipment (PPE) and changed their clothes on arrival at work and before they left the building.

People were, however, put at risk due to omissions in staff practice identified during our visit. There was a lack of robust cleaning and cleaning schedules did not support effective and enhanced cleaning. Staff had not all undertaken refresher training in Infection Prevention and Control since the start of the pandemic. Health checks were not being carried out for visitors to the building and staff take up of COVID-19 testing was not being effectively supported and overseen.

People told us they were "doing fine" despite the current restrictions imposed by the pandemic. There was signage to remind them to maintain physical distance from each other. This was not easy to achieve due to both the layout of the building, and the needs of some people living in the home to maintain their environment in ways dictated by their mental health.

People were supported to keep in touch with loved ones via telephone and the internet. Outdoor and window visits were being maintained in line with government guidance.

People were supported by staff who knew where to locate guidance detailing how to keep people safe if anyone showed symptoms or tested positive for COVID-19.

People were supported by staff who were wearing appropriate PPE.

### Rating at last inspection

The last rating for this service was Good. (published 6 April 2018)

### Why we inspected

As part of CQC's response to the coronavirus pandemic we are looking at the preparedness of care homes in

relation to infection prevention and control. This was a targeted inspection looking at the infection control and prevention measures the provider has in place. We have found evidence that the provider needs to make improvement. Please see the Safe section of this full report.

Since our inspection visit, the provider reported that they have taken action to improve the cleaning regime, to ensure visitors are screened for symptoms of COVID-19 and to ensure the systems in place to support staff testing for COVID-19 are effective.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Belle Rose Nursing Home on our website at [www.cqc.org.uk](http://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 monitor the service and 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 a breach in relation to the safe care of people living in the home at this inspection.

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

### Follow up

We requested and received assurances from the provider regarding the cleaning of touch points in the home. We requested an action plan from the provider to understand what they were doing to improve the standards of quality and safety. We received updates from the provider detailing the progress they were making. We worked with local partner agencies to monitor progress and safety and were satisfied that improvements were being made. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

# The five questions we ask about services and what we found

We always ask the following five questions of services.

## Is the service safe?

The service was not always safe.

Inspected but not rated

# Belle Rose Nursing Home Limited

## **Detailed findings**

### Background to this inspection

#### The 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.

As part of CQC's response to the coronavirus pandemic we are looking at the preparedness of care homes in relation to infection prevention and control. This was a targeted inspection looking at the infection control and prevention measures the provider has in place.

#### Inspection team

The inspection was carried out by one inspector.

#### Service and service type

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

The service 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

This inspection visit took place on 2 February 2021. We announced the inspection the day before we visited to discuss the safety of people, staff and the inspector with reference to the COVID-19 pandemic.

#### What we did before the inspection

We reviewed feedback gathered from the provider about changes they had made to improve their response to the COVID-19 pandemic following a support visit from the Dorset NHS Clinical Commissioning Group (CCG) Quality Improvement Team. Prior to the visit we requested copies of infection control policies and their most recent infection control audit. We also reviewed feedback from the local authority and CCG.

#### During the inspection

We spoke with two nurses and the housekeeper during our visit. The day after our visit we spoke with another nurse and the provider by telephone. We spoke with two people who lived in the service and looked around the building. We reviewed cleaning records, an infection control audit, guidance for staff and records relating to staff testing for COVID-19.

#### After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at cleaning schedules, quality assurance records and information related to COVID-19 testing. We also sought feedback related to infection control from health care professionals who regularly visit the service.

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as Good. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

Preventing and controlling infection; Assessing risk, safety monitoring and management;

- Staff were not being tested in line with government guidance about test frequency. This guidance outlines that one PCR test and two lateral flow tests (LFT) should be done each week. This meant there was an increased risk they could transmit COVID-19 in the home if they were unknowingly infected and not displaying symptoms. Staff told us they would be tested however, they told us the process of getting tested was challenging. One member of staff had not yet taken a PCR test for COVID-19. Two further staff had not yet done a LFT and had only taken one PCR test in the two weeks prior to our visit. The oversight for tests done by staff at home was not robust and staff had not documented the outcome of tests they had taken.
- There was no system in place to ensure that frequently touched points in the home were cleaned regularly when the housekeeper was not working. The housekeeper told us they did not know what happened when they were not at work and two nurses told us these points would only be cleaned if they were obviously dirty. The provider acknowledged that the need to clean touch points repeatedly had not been identified in their response to the risks associated with the pandemic. This meant door handles, bannisters etc might not be cleaned for long periods of time including over the weekend, putting people and staff at risk of cross infection.
- There was information reminding visitors about the impact of the pandemic on the front door of the property. However, health checks and temperature checks were not always carried out on visitors to the home and grounds. Records indicated that these checks had not been carried out since September 2020. On arrival the inspector had their temperature taken but no questions were made about their health. One nurse told us they were not sure if health checks were made of visiting relatives and health professionals.
- A member of staff who had responsibility for maintaining hygiene in the home had not received updated infection prevention and control (IPC) training since the start of the COVID-19 pandemic. We asked for information to be provided regarding staff IPC training. We did not receive this information. Dorset NHS Clinical Commissioning Group (CCG) Quality Improvement Team had offered the provider free IPC training for staff in September 2020, the provider did not take up this training. IPC training had not been effectively implemented and the resultant omissions in practice put people and staff at risk of harm. For example, staff had not identified the lack of touch point cleaning as a potential risk during the pandemic.

This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our visit the provider sent us information about staff testing and assured us that they were now recording this information in the home and enhancing their oversight. They also provided a record of touch

point cleaning. A visiting health professional verified that changes were made to ensure appropriate health checks were made of all visitors to the home. We have not been able to review whether these changes are effective and fully embedded.

- Actions had been taken to replace equipment such as bins following recommendations made by the CCG Quality Improvement Team. This had reduced the risks associated with cross infection.
- Improvements had been made following advice from the CCG Quality Improvement Team and staff were using PPE effectively and safely. Staff told us they had been assessed as competent in their use of PPE and we saw documentation supporting this.
- Social distancing was difficult to achieve within the home due to the layout and the way people used their environment to manage their mental wellbeing. There was some signage visible but additional signage to remind people and staff to maintain appropriate spacing in challenging spaces such as the office and the lift would support distancing.
- Staff told us that they would go to the guidance to manage any infection outbreaks and to ensure that admissions to the home were managed safely.
- The provider's infection prevention and control policy was up to date and they had a COVID-19 Management policy in place.



This section is primarily information for the provider

## Enforcement actions

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

| Regulated activity   | Regulation   |
|--|--|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment   |
| Treatment of disease, disorder or injury                       | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br>People were not protected from receiving unsafe care and treatment and avoidable risk because the provider/registered manager were not doing all that was reasonably practicable to mitigate risks of cross infection at the service.<br>12(1) (2) (h) |

### **The enforcement action we took:**

A warning notice was served which required the provider/registered manager to make urgent improvements by 18 March 2021.