

Barnby Gate Limited

# Belvoir Home Care Home

## Inspection report

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Lincolnshire  
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17 February 2016

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### Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

We carried out an unannounced comprehensive inspection of this service on 5 January 2015 when we found that there were breaches of legal requirements. We found that medicines had not always been managed safely, people had not been consistently supported to eat and drink enough and there were not enough staff on duty. We also found that the registered provider had not completed robust quality checks. This latter shortfall had led to the persistence of the problems noted above and also had contributed to people not being consistently protected from the risk of accidents.

After our inspection of 5 January 2015 the registered provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. As a result we undertook a further unannounced comprehensive inspection on 3 July 2015. We did this to check that the registered provider had followed and completed their plan and to confirm that they now met the legal requirements. During this inspection we found the registered provider had made improvements in the specific areas we had identified and had met the legal requirements in the breaches. However, we recommended that further developments should be made in relation to each of the shortfalls we had previously identified. We said that this was advisable to ensure that the improvements that had been made were sustained.

On 23 November 2015 we received information about concerns in relation to the service. As a result we undertook an unannounced focused inspection on 17 February 2016 to look into those concerns. The concerns related to an accident that had occurred when a person who lived in the service had opened a window that was located above ground floor level. They had then fallen out and been injured. We completed the inspection to check that suitable provision was in place to help reduce the risk of a similar event happening again.

This report only covers our findings in relation to the concerning information. You can read the report from our last comprehensive inspection and focused inspection, by selecting the 'all reports' link for Barnby Care Ltd on our website at [www.cqc.org.uk](http://www.cqc.org.uk)

Belvoir Home Care Home is registered to provide accommodation and personal care for up to 24 older people most of whom live with dementia. The service is close to the centre of Grantham.

There was a manager who had been in post at the time of the accident. They had applied to be registered with us but at the time of the inspection visit we had not completed our consideration of the application. Since our inspection visit we have registered the 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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Due to the manager not being registered with us at the time of our inspection, we only refer in our report to the 'registered provider'. This is the company that owns and is registered with us to operate the service.

In this report we refer to windows that were located above ground floor level, had sections that opened and were accessible to people who lived in the service.

New safety latches had been fitted to all of these windows. This provision helped to ensure that people who lived in the service were protected from the risk of accidental injury when opening the windows.

The registered provider had completed suitable quality checks to ensure that the safety latches remained in good working order. This had enabled the registered provider to ensure that people who lived in the service were kept safe from the risk of accidents when opening the windows.

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

We always ask the following five questions of services.

### Is the service safe?

Suitable safety latches had been fitted to all of the windows to enable them to be safely opened.

However, we have not revised the rating for this key question, to improve the rating to 'Good'. This is because we need to be sure that the registered provider will continue to operate suitable arrangements to secure the windows so that people are kept safe.

We will review our rating for 'safe' at the next comprehensive inspection.

**Requires Improvement** ●

### Is the service well-led?

Suitable quality checks had been introduced that enabled the registered provider to ensure that the safety latches remained in good condition. These checks were designed to quickly identify and resolve any defects that may occur so that people could continue to safely open the windows.

However, we have not revised the rating for this key question, to improve the rating to 'Good'. This is because we need to be sure that the registered provider will carry on completing effective checks to ensure that there are robust arrangements to enable people to safely open the windows.

We will review our rating for 'well led' at the next comprehensive inspection.

**Requires Improvement** ●

# Belvoir Home Care Home

## **Detailed findings**

### Background to this inspection

We undertook a focused inspection of Belvoir Home Care Home on 17 February 2016 to follow up on concerning information that we had received. Our inspection was completed in order to check that people who lived in the service were protected from the risk of accidental injury when opening the windows.

Our inspection was unannounced and the inspection team consisted of a single inspector.

We inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led? This was because the concerning information indicated that the registered provider was not meeting legal requirements in relation to these sections.

During our inspection we spoke with a senior care worker and two care workers. In addition, we spoke by telephone with the registered provider. We examined each window located above ground floor level that had sections which opened and which were accessible to people who lived in the service. We tested the operation of all the safety latches fitted to each window. In addition, we looked at documents that described how the registered provider had assessed and managed the risk of accidental injury resulting from the windows being opened. Immediately after the inspection we again spoke and corresponded with the registered provider. This was because we needed to seek further assurances about how people were being kept safe when opening some of the windows.

# Is the service safe?

## Our findings

We received concerning information that referred to an accident which had involved a person living in the service being accidentally injured after opening a window and falling out. The window in question was located above ground floor level. It had sections that could be opened and which were large enough to enable a person to fall. After the incident we consulted with other regulators who are also involved in helping to avoid accidents occurring in health and social settings. We established that the window used by the person had been fitted with a safety latch that did not comply with national guidance. This was because the latch was not robust and was not lockable. This meant that it could easily be released so that the window could be opened in a way that increased the risk of accidental injury.

After the incident the registered provider told us that a risk assessment had been completed in relation to each of the windows in the service located above ground floor level. This had been done to establish what additional measures needed to be put in place to reduce the risk of someone accidentally injuring themselves. The registered provider said that as a result of these risk assessments new safety latches had been fitted to all of the windows in question. They also said that the new safety latches complied fully with national guidance in that they were robust and lockable. This meant that they prevented windows from being opened far enough to allow someone to fall out of them, reduced the risk of entrapment, could withstand a reasonable amount of force if someone pushed on them and could not be released without being unlocked by staff.

We were told that the risk assessments had considered a number of relevant factors such as the location of each window, its accessibility, size of any sections that could be opened and the risk of entrapment. We found that the records of the risk assessments did not fully describe how these factors had been considered. However, we noted that in each case a decision had been made that the most effective response would be to fit a suitably designed safety latch to the windows concerned.

We identified all of the windows located above ground floor level that had parts which could be opened and that were large enough to constitute a risk of falling or entrapment. We found that 12 of these windows had been fitted with a safety latch of the correct design. They had a strong metal chord that attached securely to the window frame and to the structure of the opening part. Most of them were secured by recessed screws although a small number were fixed by a toggle device due to the construction of the window frame. All of them had a lock that could only be opened by the use of a security key. We noted that when fully extended the devices enabled the windows to only be opened to the distance recommended by national guidance. This effectively reduced the risk that someone would be able to open them far enough to fall or to become entrapped.

However, we noted that four windows that had parts which could be opened had not been fitted with safety latches. The registered provider said that this was not necessary because the windows in question were relatively inaccessible due to their height from the floor. In addition, they said that the opening sections were too small to pose a risk of accidental injury due to falling or entrapment. When we expressed reservations about these conclusions the registered provider said that they had revised their risk assessment

and sent us photographs to show that each window had been suitably secured.

We found that spare keys for the safety latches had been taped to the underside of the window sills located in bedrooms. The registered provider said that this had been done to enable people with mental capacity to unlock the safety latches if they needed to leave the building in an emergency. However, we noted the windows in question were not a recognised escape route should there be a need for people to quickly leave the premises. In addition, we noted that spare keys had also been placed under the window sills in bedrooms that were occupied by people who lacked mental capacity. These people were not able to make informed decisions about their personal safety and so the arrangement increased the likelihood that they would use the keys to release the safety latches and place themselves at risk of accidental injury.

When we raised this matter with the registered provider they acknowledged that the spare keys needed to be removed and promptly informed us that this had been done. In addition, they assured us that new arrangements had been made to ensure that staff consistently had access to a master key to override each lockable safety latch if requested to do so by a member of one of the emergency services.

The registered provider also said that robust alternative arrangements would be introduced to ensure that people with mental capacity could elect to open their windows beyond the limit established by the safety latches if it was safe for them to do so. These developments were necessary to keep people safe while respecting their legal rights.

## Is the service well-led?

### Our findings

After the accident the registered provider told us that robust quality checks had been introduced to ensure that safety latches fitted to the windows remained in good working order. They said that this was necessary to ensure that any defects could be quickly identified and resolved so that people were suitably protected from the risk of accidental injury.

The registered provider said and their written risk assessments confirmed that these checks needed to be completed on a weekly basis. We found that the quality checks had regularly been completed to ensure that safety latches continued to ensure that the windows could only be opened safely.