

Kross Investments Limited

Belton House Retirement Home

Inspection report

2 Littleworth Lane
Belton In Rutland
Oakham
Leicestershire
LE15 9JZ

Tel: 01572717682
Website: www.beltonhouse.co.uk

Date of inspection visit:
03 August 2022

Date of publication:
26 October 2022

Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Is the service effective?

Inadequate ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

About the service

Belton House Retirement Home is a residential care home providing personal care to up to 30 older people. At the time of our inspection there were 21 people using the service. Accommodation is over two floors of a large period property with bedrooms on the first floor serviced by a lift.

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

People were not supported safely. Risks to peoples' safety were not assessed or monitored effectively and were not well managed. Incident records were not reviewed, and not enough action was taken to minimise the risk of further incidents. Care plans did not contain sufficient information to guide staff as to how to support people to manage specific risks associated with their needs. Accidents and incidents were not always recorded and analysed in a timely manner. An allegation of abuse had not been reported to the Care Quality Commission or the safeguarding team, which meant we were unable to check the provider had taken appropriate action in response to these events. Medicines were not always managed safely. The risk of the spread of infection was not well managed.

The providers' governance processes did not highlight the concerns we found at this inspection. Quality monitoring and management oversight continued to be ineffective at identifying and addressing shortfalls in areas such as medicine administration, the prevention of infection, health and safety and care planning.

Staff did not receive the support and guidance they needed to be effective in their roles and meet people's needs. The provider had not identified that staff required training around individual health needs and conditions, such as distressed behaviours and mental health. Staff did not always support people to access healthcare and treatment in a timely manner.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support good practice.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 15 May 2021) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations. This is the third consecutive inspection where the provider has been rated requires improvement.

Why we inspected

We carried out an unannounced inspection of this service on 19 March 2021. Breaches of legal requirements were found. We served Warning Notices in relation to Regulation 12 (Safe care and treatment) and

Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We carried out an infection prevention and control inspection in January 2022 and found the breach of Regulation 12 had been met.

We undertook this focused inspection to check the provider now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed to inadequate. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Belton House Retirement 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 monitor the service and will take further action if needed.

We have identified continued breaches in relation to consent to safe care and treatment 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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?

The service was not safe.
Details are in our safe findings below.

Inadequate ●

Is the service effective?

The service was not effective.
Details are in our effective findings below.

Inadequate ●

Is the service well-led?

The service was not well-led.
Details are in our well-led findings below.

Inadequate ●

Belton House Retirement 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

This inspection was carried out by two 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.

Service and service type

Belton House Retirement Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Belton House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post. A new manager was in post and was in the process of applying for registration with the Care Quality Commission.

Notice of inspection

This inspection was unannounced.

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 and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with three people who used the service and seven relatives to gain their views about the care and support provided. We spoke with five staff including the manager, care staff, housekeeping staff and a cook. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with a visiting social care professional.

We reviewed care plans and care records for seven people and sampled medicine records. We looked at three staff recruitment files and reviewed a range of records, including staff training records and key care policies and procedures, that related to the day to day management of 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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Preventing and controlling infection.

- Risks to people were not safely managed. Risks were not adequately assessed and the provider was not doing all that was reasonably practical to mitigate risk.
- People's care plans and records did not provide adequate guidance for staff on measures to take to keep people and staff safe, particularly where people communicated through distress or disinhibited behaviours.
- For example, we had to intervene on several occasions when one person began to undress in communal areas in front of other people. We also had to intervene when a person became increasingly distressed in a communal area. The person did not receive any staff intervention or support until they experienced a loss of dignity in the reception area.
- Two people had a known history of disinhibited behaviours. Staff failed to monitor or sufficiently engage with either person during the course of our inspection.
- We identified two safeguarding incidents involving people who demonstrated disinhibited behaviours to other people and to staff. These had not been sufficiently investigated or alerted to relevant safeguarding authorities to ensure sufficient, timely action was taken to keep people safe.
- One person's care plan stated they were at risk from poor skin tissue viability and required staff to complete a skin inspection record every day. This was important to enable early identification and intervention in the event of wounds or pressure areas developing. Staff had failed to complete skin inspection records, despite the person having a current skin wound.
- Accidents and incidents, including falls were not consistently analysed or action taken in a timely manner to ensure lessons were learnt and people were protected from harm.
- People were not protected from the risk of infections. We found areas of the premises were dusty and unclean. This included the laundry room which had layers of thick dust around machines and discarded, used personal protective equipment (PPE) on the floor. It is essential this equipment is safely disposed of through clinical waste systems to avoid the risk of cross contamination.
- Some areas of the premises had a strong malodour. This included two chairs in the lounge area and two people's rooms. Upon investigation, we found one person's flooring was soiled and a second person's bed had been re-made by staff despite the sheets soiled with bodily fluids. This meant people were at risk from infections due to cross-contamination and poor hygiene management.

Risks to people were not robustly captured as part of care planning and risk assessing processes. The provider did not have thorough oversight of accidents and incidents. People were not protected from the risk of infections. This exposed people to a risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was facilitating visiting in care homes following the most up to date guidance.
- We observed staff were wearing face masks and using PPE when they supported people.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from the risk of abuse.
- Incidents involving disinhibited behaviours from people to other people and to staff, had either not been acted on, or allegations unsubstantiated by management without any further investigation or referral to external agencies.
- Staff had been provided with safeguarding training. However, when we spoke with staff, they were unable to demonstrate they had the skills and knowledge required in relation to safeguarding to identify when a concern should be raised.
- The local authority had investigated two safeguarding incidents and substantiated that staff had failed to take timely action to enable people to access medical treatment immediately following incidents.

The provider did not take timely action to protect people from abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- People told us they felt safe at the service. However, we received mixed feedback from relatives about their family member's safety. Comments included, "There has been a lot of staff changes and heavy use of agency staff which has had a negative impact on care. I have been sat in the waiting area and saw one person fall backwards. They hit their head on the wall. Staff didn't seem at all concerned, they had a negative attitude," and "There appear a lot of different staff and I think [Name] is safe. Although a male resident walked into [Name's] room unsupervised whilst I was visiting and then left, which was unsettling," and "Staff handle situations very well and [Name] is safe."

Using medicines safely

- Peoples' medicines were not consistently managed safely.
- We observed a staff member administer medicine to a person after dropping them on the floor. This put the person at risk from cross-infections.
- Where people received their medicines covertly (disguised in food and drink), instructions were on their medicine administration records (MAR). However, care plans did not include a copy of the GP guidance and authorisation to support this process safely and demonstrate best interest processes had been followed. The manager told us they were unable to locate these protocols and would obtain copies from people's GP to keep on file.
- Daily temperature checks were in place to monitor medicine storage areas. However, we reviewed the temperature of the fridge in the morning and in the afternoon of our inspection and found it to be significantly higher than the temperature staff had recorded of 8 degrees celsius. We found the temperature was consistently 13.9 degrees celsius. This meant medicines were not consistently stored at the recommended temperature to ensure they remained effective.
- Medicine records and stock checks were in place. We sampled records and found these to be accurate. However, we found one topical medicine that had an expiry date of January 2022 and was still in use. It is important to use medicines within the expiry date to ensure they remain safe and effective to use. Staff immediately removed the medicine for disposal.

Staffing and recruitment

- The provider was reliant on agency staff to ensure sufficient numbers of staff were deployed to meet people's needs.

- We reviewed staffing rotas from 18 July 2022 to the date of our inspection. Rotas showed staffing levels were maintained overall, but some staff were working excessively long hours. Although one staff member told us this was their choice, the provider has a responsibility to ensure the hours staff work are reviewed and risk assessed to ensure staff remain safe to work.
- The provider used a dependency tool to assess how many staffing hours were required to meet people's needs. This did not take into account people's individual needs, environmental constraints, such as building layout, or peak times during the day. The manager told us they would be implementing a new dependency tool following our inspection.
- Staff were safely recruited. The provider undertook pre-employment checks including right to work status checks with the Disclosure and Barring Service. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last comprehensive inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff had not been provided with sufficient training to meet people's needs
- We reviewed the current staff training matrix and found only one staff member had completed training entitled 'behaviours that challenges'. No staff had completed training in mental health and only six staff had completed training in dementia. People were at immediate risk of harm as staff did not have the skills and knowledge required to keep them, and others, safe from harm.
- The provider relied heavily on the use of agency staff to maintain safe staffing numbers in the service. Agency profiles showed these staff did not have any specific training to enable them to support people effectively where they presented a risk to themselves or to others.
- We observed three members of staff who were unable to converse easily in English with inspectors or people, other than single phrase guidance. These staff members frequently reverted to speaking in their first language in front of people, which they were unable to understand. This presented a risk that people's needs would not be met through poor staff understanding and communication.
- During our inspection, these staff received very little supervision or guidance and were frequently seen to be sitting or standing away from people in communal areas, with little or no engagement or interaction.

The provider had not ensured staff received appropriate support, training and supervision as is necessary to enable them to carry out the duties they are employed to perform. This is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our inspection, the provider arranged additional training and supervision of staff.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People did not always receive a full assessment of their needs prior to moving into the service. Pre-admission assessments were basic and did not fully capture people's specific needs, preferences and outcomes they wanted from their care.
- Staff did not always support people to access healthcare services in a timely way. One relative told us, "When [Name of relative] was unwell, I suggested they needed to see a doctor. It was brushed off by staff. The doctor came to see them and found they had a health condition that required anti-biotics. There seems to be no-one to advocate for [Name] or who is well informed about [Name's] health conditions." A second relative described miscommunication in registering a person with a GP that resulted in them receiving the

wrong medicine. They felt staff had handled things badly and the situation could have been avoided if staff had worked with health agencies more effectively.

- Staff did not always deliver care in line with best practice. For example, they consistently failed to provide timely intervention and reassurance when people became distressed or anxious. Care plans did not provide information around positive behaviour support and interventions to enable staff to meet people's needs.
- We did find examples where staff had worked effectively with health and social care professionals to ensure people's needs were met. These included GPs, district nurses and social workers.

Supporting people to eat and drink enough to maintain a balanced diet

- We observed staff providing people with meals and drinks. However, where people were at risk of poor nutrition, the level of support provided was not always recorded. This is important to ensure people are reaching their daily target food and fluid intake required to maintain good nutrition and hydration.
- People's weight was regularly recorded, though records did not provide a clear audit as to whether the person had gained or lost weight from the previous weight recorded.
- Relatives expressed concern around meals and drinks. One relative told us pureed meals were not well presented and 'looked disgusting'. A second relative described how their family member enjoyed a specific breakfast but had only been offered this once since moving to the service.

Adapting service, design, decoration to meet people's needs

- The service had several communal areas that people were able to use. However, there was a lack of stimulation and items for people to interact with, particularly people who were living with dementia. There was little signage to guide people to orientate around the premises independently.
- The property had extensive landscaped grounds which people rarely accessed. Instead, they were able to access a fenced paved courtyard. We found this was overgrown with weeds and included discarded furniture and debris. The area was uninviting and lacked any planting or landscaping to provide people with sensory stimulation or enjoyment.
- People were able to personalise their rooms. However, we found one person's room had severely stained flooring in the bedroom and en-suite. The manager told us they thought this had been approved for replacement but was unable to provide any evidence of this.
- People had access to the main staircase which presented a significant risk if people were to access this independently. People had individual risk assessments regarding access to this. However, we observed people who walked with purpose frequently pointed to the stairs and paintings on the wall. The manager told us they would ensure risk assessments were reviewed to ensure they remained current.

Ensuring consent to care and treatment in line with law and guidance

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Always use the following sentence:

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions

relating to those authorisations were being met.

- People's care plans included reference to their mental capacity but assessments were not decision specific to support people to make decisions and choices about their care and support.
- One person's DoLS authorisation included conditions around incident recording. Records showed staff had failed to record any incidents, despite a reminder from management being sent in July 2022. Care records failed to evidence if incidents had actually occurred and not been recorded or if no incidents had occurred.
- The manager had submitted DoLS applications for people and had obtained urgent authorisations where appropriate.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. 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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the last inspection we identified issues around governance and oversight. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. and we issued a warning notice. At this inspection not enough improvement had been made and the service remained in breach of Regulation 17.

- Systems to monitor and improve the quality of the service were not effective in ensuring service users received safe care.
- Audits and checks had not been carried out consistently and were not effective in identifying the concerns we found at this inspection. For example, audits and checks undertaken in May and June 2022 failed to identify people's care plans and care records were not accurately completed or provided staff with sufficient information about their current needs.
- Audits had not identified cleaning resources were not sufficient to ensure standards were achieved to protect people from the risk of infections
- The provider had recruited staff to reduce the use of agency staff. However, they had not completed any skill analysis to ensure staff had the competency and skills to meet people's needs and ensure they were effective in their roles.
- There was insufficient leadership and provider oversight to support and supervise staff to ensure people received person centred care. We observed staff spending little time engaging and interacting with people outside of basic care tasks. Staff did not intervene in a timely way when people needed reassurance or supervision.
- This is the third consecutive rated inspection where the provider has failed to meet regulations and achieve a good rating as a minimum standard. This demonstrated governance systems were ineffective in addressing and sustaining improvements.

The provider did not operate effective systems and processes to make sure they assessed, monitored and improved the service. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics; Working in partnership with others

- Meetings for people who lived at the service were not taking place regularly; the last one recorded was dated October 2021. Minutes of this meeting showed people were consulted about areas of the service, such as food, activities and décor.
- We received mixed feedback from relatives regarding their involvement in their family member's care. One relative told us there was good communication, consultation and felt involved in care planning. However, other relatives felt engagement and involvement was poor. Comments included, "I would really like to know when changes are made (to family member's medication) and to have information about their medical wellbeing. Staff do call to update sometimes but the communication is not always there," and "[Name] has a care plan. We have had no choice or say in the care plan. I would just like to be listened to."
- Staff meetings took place more regularly. However, minutes reflected managers telling staff do's and don'ts rather than consulting and involving staff in decisions. One staff member told us, "Things have not been right here. We were very short staffed though this has improved with recruitment. The new manager seems good but there is a lot of work to do."
- Relatives who had had contact with the new manager were positive and felt they were approachable and took the time to listen to them.
- The provider told us they were committed to working with other agencies to ensure improvements were made and sustained to provide people with quality care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Duty of candour was not always fulfilled because incidents were not always analysed or referred, and so the service did not always identify where things had gone wrong.
- A new manager was in post; they were committed to improving communications and information sharing with relatives and external agencies.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Risks to people were not robustly captured as part of care planning and risk assessing processes. The provider did not have thorough oversight of accidents and incidents.</p> <p>People were not protected from the risk of infections</p>

The enforcement action we took:

Urgent imposing of conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>The provider did not take timely action to protect people from abuse</p>

The enforcement action we took:

Urgent imposing of conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider did not operate effective systems and processes to make sure they assessed, monitored and improved the service</p>

The enforcement action we took:

Urgent imposing of conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider had not ensured staff received appropriate support, training and supervision as is necessary to enable them to carry out the duties</p>

they are employed to perform.

The enforcement action we took:

Urgent imposing of conditions