Care Quality Commission

A Kilkenny

Belper Views Residential Home

Inspection report

50-52 Holbrook Road
Belper
Derbyshire
DE56 1PB

Tel: 01773829733

Date of inspection visit:
29 September 2021
05 October 2021

Date of publication:
20 May 2022

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Belper Views Residential Home is a residential care home providing personal care to 18 people aged 65 and over at the time of the inspection. The service is registered to support up to 25 people. The home is set over two floors, with bedrooms and bathrooms located on each floor. There are two communal lounges, a dining area and a secure garden.

People's experience of using this service and what we found
There were not enough staff to support people's needs. There was no dependency tool in place that calculated the number of staff required to meet people's needs. Staffing levels were not reviewed when the number of people using the service changed. Infection prevention and control was not always well managed to ensure people were protected from the risk of infections.

The service lacked provider and management oversight. Required audits were not always completed. Where audits were undertaken, follow up actions were not always identified or actioned. The provider did not always ensure staff and people were engaged with the running of the service.

Staff had not received the required training to support their roles or people's needs. New staff and established staff did not receive required supervision to review their ongoing support or training needs.

The provider had not ensured good oversight of the home to maintain people's care and safety. Risks to people were not always assessed and actions taken to mitigate the impact were not always completed.

Safeguarding concerns were not always reported to local authorities to protect people from harm and staff did not always demonstrate an appropriate understanding of safeguarding. There was no safeguarding policy in place specific to the service.

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

People received enough to eat and drink and people shared with us that they enjoyed their meals .

The provider worked in partnership with other professionals and referrals had been made appropriately to support ongoing health needs. Medicines were administered safely.

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

Rating at last inspection
The last rating for this service was requires improvement (published 31 January 2020).

At this inspection enough improvement had not been made and the provider was in breach of regulations.

Why we inspected
We received whistle-blower concerns in relation to management and staffing. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led to examine those risks.

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.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.
You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Belper Views Residential 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 staffing, safe care and treatment, governance, training, need for consent and safeguarding 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
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 always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Belper Views Residential 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.

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.

Service and service type
Belper Views Residential 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 did not currently have a manager registered with the Care Quality Commission. However, a manager had been recruited and was working at the home. The manager was on annual leave during the first day of inspection but was present on day two. The provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before 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. 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with three people who used the service about their experience of the care provided. We spoke with twelve members of staff including the provider, manager, administration assistant, senior care workers, care workers and kitchen staff. We also spoke with a relative of a person who used the service.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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.

Staffing and recruitment

- Staffing levels were not sufficient to meet the needs of people using the service. At the time of the inspection, three staff were scheduled during the day to support 18 people. We identified seven people who required support from two staff with moving and handling or personal care needs. This left only one member of staff to support anyone else who required assistance. There were instances when the third member of staff had medicine administration responsibilities which left no one to support people in the communal spaces or requests for support. This meant staff were not always available to provide support to people, placing them at risk of harm.
- Staffing levels had not been reviewed following changes in the number of people using the service. Since February 2021 there had been six new admissions to the service, however the staffing number had not been considered or increased.
- People had to wait for support, impacting on their dignity. We observed three occasions where communal areas were unsupervised. During one of these periods one person requested a drink and had to wait over 40 minutes until staff responded. One member of staff told us, "If we had more staff, we could spend more time being more personal instead".
- We could not be assured staff were safe to work with people. The provider's recruitment process required two references; however, these had not always been obtained. Induction for new staff was not always consistently implemented and medical questionnaires had not been completed.

Staffing levels were not sufficient to meet the needs of the people using the service, placing them at risk of harm. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the first day of the inspection and increased the numbers of staff on shift during the day.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- At our last inspection we identified risk assessments had not been completed for risks related to long-term health conditions, for example diabetes and catheter care. At this inspection we found some people still did not have specific risk assessments for their needs. This meant there was no written guidance for staff on what each person's normal presentation would look like and any symptoms that would suggest a decline in their health.
- We observed poor catheter care and staff demonstrated a lack of understanding of how to manage risks associated with catheter care. There were no risk assessments in place meaning people were at risk of harm.

● Some people presented with behaviours that challenge, placing themselves and others at risk of harm. There were no individual plans to provide guidance to staff on how people exhibiting behaviours that challenge should be assisted and managed. This meant their needs might not be met and their behaviours could escalate, placing people with behaviours that challenge, other people using the service and staff at risk of harm.
● Lessons were not always learned when things went wrong. Following incidents or accidents, care plans were not reviewed to include actions taken to prevent re-occurrence. For example, one person fell from their bed, however no review of the environment was completed to ensure the risk of further falls was minimised.

The provider had failed to ensure that people were protected from the 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.

Preventing and controlling infection
● Infection, prevention and control (IPC) protocols were not always in place to provide assurances people were protected from the risk of infection.
● We were not assured that the provider's infection prevention and control policy was up to date. The IPC policy in place was dated February 2019 and had not been updated to reflect changes to practice in relation to COVID-19. There was no specific COVID-19 policy in place, therefore we could not be assured staff had been provided with guidance to help protect people from COVID-19.
● We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. During our inspection, we found staff were not always compliant with the wearing of face masks in accordance with guidance. Risk assessments had not been completed for staff who were medically exempt from wearing face masks to consider how to reduce the risk of infection to people.
● We were not assured that the provider was promoting good hygiene practices at the premises. A domestic assistant was not on duty every day to ensure routine cleaning and cleaning of frequently touched surfaces was completed. Staff told us when the domestic was not on duty they were required to pick up cleaning tasks placing additional pressure on top of their care duties.

The provider had failed to ensure that people were protected from the risk of infection. 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 responded immediately after the inspection and ensured a domestic assistant was on duty every day.

● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse. Safeguarding referrals were not made when required. We identified two incidents which required a safeguarding referral to the local authority that had not been made, which meant all measures to ensure this person's safety had not been taken.
●The provider's safeguarding policy was not bespoke to the service. This meant there was no specific guidance on how the provider would respond in the event a person was abused, or at risk of abuse.

The provider had failed to ensure that people were protected from the risk of harm. 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.

Using medicines safely

● Staff managed medicines safely and people received their medicines as prescribed. However, the oversight and monitoring of medicines was not effective. We have referred to these concerns in the well-led section of this report.

Requires Improvement

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had not always received the required training to carry out their role effectively. For example, some staff had not received up to date training in safeguarding. When we spoke with staff, we were not assured by their understanding of what safeguarding meant and whether they would recognise or respond appropriately.
- Staff were not adequately trained to support people with behaviours which challenge. We observed inconsistent management of people's behaviour during our inspection. Staff told us they did not feel confident in this area, one member of staff said, "I don't think we are properly trained [for people with these needs]".
- Staff had not received regular supervisions or ongoing support to review their practice. Competency checks had not been carried out to ensure staff were working in line with training and best practice. This placed people at risk of receiving unsafe care.
- The provider did not have an accurate overview of staff training. The training matrix in place showed dates of refresher training that had been assigned but did not evidence original training dates.
- Some staff who provided care were not included on the provider's training matrix. Therefore, we could not be assured they had received the required training to provide safe care.

The provider had failed to ensure staff received appropriate support and training to enable them to carry out the duties they are employed to perform. This placed people at risk of harm. This was a breach of regulation 18(2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Act 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.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
●The principles of the MCA were not always followed. Mental capacity assessments were not always in place for people who required them.
●We identified two people who had a mental capacity assessment in place, however no best interest decisions were recorded with them. Therefore, it could not be demonstrated that care was being provided in the least restrictive way in line with MCA legislation.
● DoLS authorisations had been completed for some people, however there was no record of how this decision had been made. People's DoLS paperwork was not available within their care files meaning we could not be assured the provider was working to meet any conditions of people's DoLS authorisations.

The provider had failed to act in accordance with the requirements of the MCA. This placed people at risk of harm. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider did not always use tools in line with best practice to assess people's needs. For example, there was no clear process for recording people's weights and therefore no record of any action taken should there be a concern in relation to a person's weight loss or gain.
● It was not always clear how the provider ensured people's choices were assessed. Some people had communicated their choices to stay in their room and this had been respected. However, some people remained in the communal spaces and were given limited choices of how to spend their day. Staff told us that people's choices were not always acknowledged. One member of staff told us that some people like to go to bed early, however management had told staff that people can only go to bed after 7.00pm.

Supporting people to eat and drink enough to maintain a balanced diet
● Information about people's dietary requirements was not clearly available for kitchen staff.
There was no record in relation to people's known allergies or dietary requirements. This placed people at risk of harm of receiving food that was unsafe for them to eat.

The provider responded immediately after the inspection. They confirmed people's dietary requirements were now clearly recorded and available in the kitchen.

● People received three meals a day, plus snacks and drinks throughout the day. Two people told us they enjoyed the food.

Adapting service, design, decoration to meet people's needs
● The provider had not considered how further adaptations to the environment could be made to promote good practice in dementia care. For example, there was a lack of signage to support people to navigate around the home. As some people at the service were living with dementia, further adaptation was needed to ensure the environment was dementia friendly.
● Some areas of the home were purposely adapted to meet people's needs. The bathrooms within the home had been recently refurbished to a high standard and were accessible for people with physical disabilities.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- The provider had positive working relationships with health and social care professionals. During the inspection we observed a range of professionals such as district nurses, occupational therapists and mental health workers visit people.
- Recommendations made by other professionals were carried out as directed. A visiting healthcare professional told us they found staff to be helpful and generally followed their advice.

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 requires improvement. At this inspection this key question has now deteriorated 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
● At the last inspection we had reviewed the systems in place and the need for these to be embedded. At this inspection we found these systems were no longer in use and the service was not well managed.
●The provider had no dependency tool in place to demonstrate how they calculated the number of staff required to meet the needs of the people using the service. Staffing numbers had not been reviewed following new admissions and this meant staffing levels were not always safe, placing people at risk of harm.

● Quality assurance systems were either not in place or not implemented consistently. For example, there were no audits in place to monitor safeguarding, DoLS or behaviour charts. This meant we could not be assured the provider had any oversight of these areas. Audits that were in place for care plans, IPC, health and safety, mattress and pressure relieving equipment were all out of date. Therefore, current risks to people had not been identified and recorded.
● Audits had not been used to improve safety or drive improvement. For example, the last three medication audits were marked as failed, but no action plan was in place to address the failed areas. This increased the risk of people receiving their medicines in an unsafe manner.
●There was no clear system in place to monitor action plans that were completed. For example, a catering audit completed in August 2021 had identified people's allergy and dietary information was not in the kitchen. This action had not been completed meaning people could have been at risk of harm from receiving a diet inconsistent with their needs.
● Accidents and incidents had not been analysed to identify trends or prevent re-occurrence. Information from accident and incident forms completed by staff had been copied into one document, however this did not provide any analysis or further scrutiny to mitigate risk to people.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Policies were either not in place or did not provide service specific information to guide staff on best practice. Therefore, it was not clear on how the provider planned to ensure the service would achieve good outcomes for people.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not always ensure a positive culture was promoted within the home. Staff did not always feel able to approach management when they had concerns. Staff told us they did not feel supported by management and described staff morale as low.
● Staff did not always receive feedback from management when required, for example following accidents or incidents. This meant staff were not provided with information about what they needed to do to improve their practice.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Opportunities for engagement with people and their relatives was minimal. We found no record of any meetings held with the people who used the service or attempts to gather their feedback. The last questionnaires sent out to relatives was in February 2019. This meant people had limited opportunity to contribute to the running of the home.
● Staff were not engaged or empowered to be involved in the running of the service. There had been no recent staff meetings to share information about the home or any improvements planned.
●After the first day of the inspection the provider requested feedback from staff. However, staff were not offered privacy to give feedback meaning we could not be assured by the outcome of these questionnaires.

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
● The provider had employed a manager who had been working at the service since March 2021. At the time of inspection, the manager was not registered with CQC.
● The provider had failed to notify us of significant events which occurred at the service. These notifications enable us to monitor the service and any actions taken.

We are looking at potential failures to notify and will report on our findings once completed.

Working in partnership with others
● The provider had working relationships with partner agencies such as the local authority and relevant healthcare professionals.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured when people were unable to consent, mental capacity assessments and best interest decisions were completed in accordance with the Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured risk assessments were in place, fire safety concerns were addressed and IPC guidance followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured their processes were robust to protect people from harm. Staff had not received training relevant to their role to enable them to recognise different types of abuse and how to report concerns.

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 provider did not have established systems and processes to ensure the safety of the services being provided. These services had not been assessed, monitored and ongoing improvements made. Risks had not been reviewed placing individuals and others at risk of harm. Experience of using the service had not been obtained from people. Communication with people using the service and those important to them had not been established to share how the home was being managed.

The enforcement action we took:

Notice of Decision to impose conditions to restrict admissions, ensure sufficient staffing and reporting of audits.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always sufficient levels of staff to respond to people's needs. The provider had not deployed sufficient numbers of staff to make sure they could meet people's needs. Staffing levels had not been continuously reviewed to adapt to the changing needs of people. The provider had not ensured the staff received training at a relevant level to provide them with the skills to keep people safe at all times.

The enforcement action we took:

Notice of Decision to impose conditions to restrict admissions, ensure sufficient staffing and reporting of audits.