Mr David Arthur Salter

Belton House Retirement Home

Inspection report

Littleworth Lane
Belton in Rutland
Oakham
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Ratings

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

Overall summary

We carried out an unannounced inspection of the service 23 February 2015.

Belton House provides accommodation for up to 22 people who require personal care. On the day of our inspection 14 people were using the service.

There was not a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. At the time of our visit there was an acting manager working at the service. They were in the process of applying to become the registered manager.

Summary of findings

During our last inspection on 30 September 2014 we asked the provider to take action to make improvements to protect people living at the home. The provider was not meeting one of the Regulations of the Health and Social Care Act 2008. This was in relation to people's care and welfare. Following that inspection the provider sent us an action plan to tell us the improvements they were going to make. During this inspection we found that the provider had made some improvements but there were continuing breaches to this regulation (and its equivalent from 1 April 2015).

People told us they felt safe living at Belton House. However, we found there had been a high number of unwitnessed falls and many of these had occurred at night when there were only two members of staff on duty. One person was at risk because they did not receive the assistance they required to eat their meal.

Medicines were not always stored in a safe way and administration records were not always accurately completed. There was no clear audit trail of medicines received and this meant that neither we nor the provider could check to see if medicines had been administered as prescribed by the doctor.

Staff knew how to recognise the signs of abuse and what action to take should they suspect it. This included contacting other authorities such as the CQC and local authority safeguarding team.

People said that staff were competent and knew how to meet their needs. All new staff received induction training and there was an ongoing training programme in place. Not all staff had up to date training about dementia and equality and diversity.

People were asked for their consent before receiving care and support and were able to make choices. Staff did not routinely assess people's capacity to make decisions. We have made a recommendation about mental capacity assessments.

The risk of malnutrition was assessed and where risk was identified appropriate action was taken. People were provided with sufficient amounts to eat and drink. People had access to the healthcare services they required.

People said they liked the staff and interactions between staff and people were kind and helpful. Some people did not have a bath or shower on a regular basis. Visiting was unrestricted for people's friends and family and they were made to feel welcome.

People's care plans were personalised so that people received care and support in the way they preferred. However, there were limited opportunities for people to pursue their hobbies and interests and some people were unoccupied and without interactions for long periods of time.

People said they would feel comfortable raising a concern or complaint.

Systems in place to monitor the quality of service provision were not as effective as they could be.

We found one breach of the Health and Social Care Act 2008 Regulations during this inspection. You can see the action we have told the provider to take at the end of this report.

Summary of findings

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.

People who lived at the home were put at risk because of insufficient staffing numbers and lack of effective medicines management.

Staff knew how to recognise the signs of abuse and what action to take when abuse was suspected.

Requires Improvement

Is the service effective?
The service was not effective.

Staff had not received all the training they required to support them to meet people's needs and keep them safe.

Staff did not assess people's capacity to make decisions when the need arose.

People had sufficient amounts to eat and drink and access to the healthcare services they required.

Requires Improvement

Is the service caring?
The service was not consistently caring.

People were not routinely involved in making decisions about their care and support.

Some people's dignity was not always protected because arrangements for bathing and showering did not meet their needs.

Not sufficient evidence to rate

Is the service responsive?
The service was not responsive.

People had their needs assessed and care plans were in place for each identified needs.

Opportunities for people to follow their hobbies and interests were limited.

People said they knew how to make a complaint should they need to.

Requires Improvement

Is the service well-led?
The service was not well led.

There was a new acting manager in post. There had been a period of instability because of frequent changes to management arrangements.

Requires Improvement

Summary of findings

Systems in place to monitor the quality of service provision were not always effective.	

Belton House Retirement Home

Detailed findings

Background to this 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place 23 February 2015 and was unannounced.

The inspection team consisted of two inspectors.

On the day of the inspection we spoke with four people who used the service and four members of staff. We also spoke with the acting manager.

We looked at the care records of six people along with other records relevant to the running of the service. This included policies and procedures, records of staff training and records of associated quality assurance processes.

Some of the people who used the service had difficulty communicating with us as they were living with dementia or other mental health conditions. 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.

Is the service safe?

Our findings

At our last inspection in September 2014 we identified some concerns with care and welfare because care plans and risk assessments did not reflect current needs and risk and staff were not consistently meeting people's needs effectively. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which following legislative changes of 1st April 2015 corresponds with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan outlining how they would make improvements.

At this inspection we found that while improvements had been made and the provider was now complying with this regulation there were continuing challenges and difficulties. People told us there were enough staff on duty. Some staff told us that people sometimes had to wait for staff to attend to them. Three people required two members of staff to help them with mobility. There were three members of staff on duty during the day and two at night. This meant that at night if the two staff were busy with one person then they were not available to respond to other people's needs and keep them safe.

Records of accidents and incidents showed that there had been 14 falls since our last inspection. Nine of these falls occurred unwitnessed by staff and the person was either found on the floor or was able to summon assistance after they had fallen. The majority of these falls had occurred at night when there were only two staff on duty. This meant there were not enough staff to attend to the people who had fallen and to other people.

People's care plans had risk assessments of activities associated with their personal care and support. Plans were in place to manage those risks. For example, risk assessments and management plans were in place for risk of developing pressure sores and risk of malnutrition. Staff told us about risk assessments for moving and handling and knew about people's individual needs and the equipment they required

One person preferred to spend much of their time in bed. At lunch time staff had brought their meal and left it with them on a tray. The person was lying almost flat with the tray on their tummy. This was not safe and we asked staff to intervene.

People told us they received their medicines at the right time and as prescribed by their doctor. However records showed that one person's medicine had been out of stock for six days and prior to this there were two missed signatures on the administration chart. We could not check to see if the medicine had been given because there was no record of the amounts received. The acting manager informed us that the stock issue was due to a discrepancy between the doctor's prescription and the prescription received. This showed that record keeping in relation to medicines required improvement.

There was no monitoring of room temperatures where medicines were stored. We checked the room temperature during our visit and this was 26 degrees centigrade which is above the recommended storage temperature.

There were no protocols in place for staff about the administration of medicines to be given 'as required'. These protocols are important so that staff know when to administer the medicines in the way prescribed. Where one or two tablets could be given the amount given was not always recorded. This meant staff may not know how much medicine the person had taken in each 24 hour period. The provider's medicines policy did not advise staff about the administration of 'as required' medicines. Recording codes were used so that staff could record when a medicine had been refused or not given for another reason. There were several recordings of 'G' which meant 'see notes overleaf' but there were no notes overleaf so we did not know why the medicine had not been given.

The acting manager informed us they were introducing a medicine audit so that any discrepancies could be identified quickly and action taken.

Staff had received training about safeguarding people from abuse. They knew how to recognise the signs of abuse and what action to take. This included contacting other authorities such as the local authority safeguarding team and the Care Quality Commission.

Maintenance staff were employed to manage the premises and equipment to keep people safe. We were informed that there was an on-going issue with the boiler system and action had been taken to rectify this. This included testing the water and de-scaling. There was also an ongoing issue with temperature control. An air conditioning unit had been installed. Some areas of the premises were uncomfortably warm during our visit. A wall thermometer

Is the service safe?

recorded a temperature of 26 degrees centigrade and this was too warm. The maintenance staff adjusted the boiler during out visit. Records showed that fire safety equipment such as alarms and emergency lights had been checked.

Is the service effective?

Our findings

People told us that staff were competent and knew how to meet their needs.

The acting manager informed us that all new staff received induction training. This ensured that new staff were made aware of best practice ways of working with people using the service. Staff also received ongoing training and supervision. There was a schedule of training booked to take place. We were informed that many staff required updating about dementia training and equality and diversity and this was planned to take place. Staff appraisal documentation had been given to all staff and a date had been set for the appraisals to take place. This meant that staff would have their performance appraised and any training and any development needs identified.

Staff we spoke with confirmed that they received training and support but one new member of staff did not have any written record of the induction they had received. The acting manager informed us that new induction programmes were being introduced. The induction programmes they showed us were comprehensive and covered the skills and knowledge required to meet people's needs and keep them safe.

People said that staff gained their consent before carrying out any care or support. They told us they could choose how to spend their day and that staff were flexible. Staff described the way they encouraged people to make choices and receive care and support in the way they preferred.

Some people had a deprivation of liberty authorisation in place. Deprivation of Liberty Safeguards (DoLS) protects people where their liberty is restricted. The acting manager told us they were in the process of making further applications to the supervisory body that had responsibility for assessing if authorisations to restrict people were necessary. Staff were clear about who had a DoLS in place and why. They knew how to apply this in the least restrictive way. A staff member explained how they managed resistance to personal care. They said "If it's for personal care, I explain what I'm going to do and step back and leave them for a few minutes. I go back and usually it's successful sometimes we need to try a different member of staff".

The Mental Capacity Act 2005 (MCA) is legislation that protects people who do not have mental capacity to make a specific decision themselves. Under the Act, people are presumed to have capacity unless there is evidence to the contrary. Staff did not always assess people's mental capacity to make decisions about the care and support they received. This is important so that where people lack capacity to make a specific decision, a best interest decision can be made.

We recommend that the provider follows MCA Code of Practice about mental capacity assessments.

People told us they liked the meals provided and had enough to eat and drink. One person said, "The food is good and there is always a choice." Another person said the meals had recently improved. People had their risk of malnutrition assessed and action was taken where risk was identified. For example, people had their weight monitored and staff informed the doctor when people lost weight. We observed staff assisting people to eat and drink where this was required. We saw that one person was not provided with appropriate assistance and asked staff to take action about this. Staff were required to keep records of some people's food and fluid intake to check that they had enough to eat and drinks. We saw that these records were kept up to date.

Care plans were in place for nutrition and hydration. Menu records showed that a varied and nutritious diet was provided. The cook informed us they were provided with the resources they required. They told us they only had to ask and showed us some new kitchen equipment they had recently asked for.

One person said they could see their doctor whenever they needed to and told us about a recent doctor's visit where some new medicine had been prescribed. Staff told us that doctors and other healthcare professionals were asked to visit as soon as a need was identified. An example was given of a person being referred to a speech and language therapist because they suspected swallowing difficulties. Records showed that staff had followed guidance and advice given by healthcare professionals.

Is the service caring?

Our findings

One person told us, "I like it here they are nice people and I can choose how I spend my time".

People said that staff maintained their privacy and dignity and treated them with respect. They also said they could have a bath or shower whenever they wanted one.

Care plans showed that baths or showers were planned for on a weekly basis. However records did not show that this was carried out and one person had not had a bath or shower for over a month. Some people had a strong unpleasant odour about them and this did not uphold their dignity. We saw that staff had asked a person's family member to assist when they had refused personal care and this had been accepted by the person. However, we did not see other people being offered a bath or shower.

Interactions between staff and people who used the service were kind and respectful although largely task focussed. There was a lack of engagement with people outside of this. We saw that some people spent a long time without any staff interaction.

One person told us they were never asked for their feedback or involvement about their care and support. We asked staff about how they made people feel like they mattered and how they involved people in making decisions about their care and support. Staff told us they treated people like a family member and would be happy for their family members to use the service if they needed to. A staff member said, "People are happy here, its calm and staff have a good relationship with people". When asked for examples about involving people, staff told us they promoted people's independence as much as possible, but we did not see this happening.

There were no restrictions on visiting and people told us their friends and family were made to feel welcome. People had access to advocacy services. One person was receiving visits from a paid representative to advocate on their behalf.

Staff knocked on people's doors before entering their rooms. People told us they could spend time in their rooms and have meals in their room if they did not want to join other people in the communal areas. We saw that people's rooms were personalised and some people had brought in their own furniture so they could set out their rooms in the way that they preferred.

Is the service responsive?

Our findings

People told us they received care and support in the way they preferred. Important information about people's life history had been recorded. This assisted staff to get to know the person. However, this information was not always used to plan and deliver care and support. There were limited opportunities for people to pursue their hobbies and interests. One person said there was enough to do and another said they did sometimes get bored. During our visit we saw that some people watched television in the communal lounge while other people did not engage in any activity. We were informed that a new member of staff had been recruited to co-ordinate and facilitate activities.

Staff knew about people's backgrounds and life histories. They gave examples of the careers peoples had followed and the things that were important to them. Some staff were not aware of people's cultural or religious needs. We were shown new documentation the acting manager was planning to introduce. This documentation was designed to make care plans more personalised and easier for staff to access important information about the person that would help them support and care for them.

Each person had their needs assessed before they moved in to check that the service could meet their needs. A plan of care was developed for each identified need. Care plans were detailed and gave clear instructions to staff about how to meet needs. For example, one person had a care plan in place about risky behaviour and triggers for this. The care plan instructed staff to use distraction techniques and stated that the person responded positively to male care staff. Staff were aware of these individual needs and preferences and described how they met these needs.

Staff did not always follow people's care plans. A person's care records showed that they had recently had a reduced appetite and required staff to assist them but we saw staff leave a meal for them without supporting them to eat it. We spoke with the acting manager who assured us that staff would be spoken with about this so that this would not happen again.

People said their family members and visitors were made welcome by staff. People's relatives were involved in the planning and delivery of care where this was appropriate.

People told us they would feel comfortable and comfortable raising a complaint or concern with any of the staff employed at the service. One person said they were aware of the provider's complaints procedure. They told us they had complained about the quality of the food and that action was taken and the food had improved. Another person told us there had been problems with the heating system for some time. We saw that the provider was addressing this but it was still an on-going issue.

The acting manager told us they maintained records of all complaints received. They gave us examples of how complaints had been used to learn and improve. A person had complained that footplates had not been used on the wheelchair. The acting manager had carried out an audit to check that all wheelchairs at the service had appropriate foot plates. Records showed that complaints were discussed with staff at staff meetings.

We were informed that satisfaction questionnaires were being sent to people and their relatives in order to gather feedback about their experience of the service.

Is the service well-led?

Our findings

Although there were some systems in place to assess the quality of the service provided in the home we found that these were not always effective. The systems had not ensured that people were protected against some key risks described in this report about inappropriate or unsafe care and support. We found problems in relation to lack of hygiene, staffing levels and the management of medicines.

These matters were a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010, which following legislative changes of 1st April 2015 corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had met with the new acting manager and would feel confident speaking with them about any issue.

A staff meeting had recently been held. Records showed that the meeting had been well attended and that attitudes, values and behaviours had been discussed along with areas of required improvement.

There was a new acting manager working at the service and they told us they had begun the process of applying to become registered as manager with the CQC. There was also a training and compliance manager employed. A staff member said, "It's quite good now. The manager is supportive and understanding. We have staff meetings.

Another staff member said "We've been on a changeover and now I think we are onto something pretty good. I like and respect the manager, they are firm but fair. They are approachable. We've just started having staff meetings."

We were informed that supervision dates and appraisal forms had been given to all staff members. This was so staff could receive feedback form their managers and informed of what action they needed to take to. Staff could also discuss their learning and development needs.

We were also told about a meeting that had been held for people who used the service and their relatives. The new acting manager had been introduced and records showed that people had been invited to put forward any ideas of suggestions to improve the service.

Staff were aware of the visions and values of the service. When asked, a staff member said their role was to "Care for and look after vulnerable people and keep them safe". Another told us that staff all needed to be practicing in the same way. They said "The care is already there and it's good. We have got a good team."

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The acting manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. We spoke with local authority care commissioners, and were informed that the provider had taken action in the majority of areas where they had identified shortfalls.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met. The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.