Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Belton House Retirement Home

Littleworth Lane, Belton-in-Rutland, Oakham, LE15 9JZ

Tel: 01572717682

Date of Inspection: 06 July 2014

Date of Publication: August 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Care and welfare of people who use services	✖ Action needed
Safety and suitability of premises	✖ Action needed

Details about this location

Registered Provider	Mr David Arthur Salter
Registered Manager	Mrs Sarah Jane McCann
Overview of the service	Belton house is a care home without nursing. The service provides care and support for a maximum of 22 older persons.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 6 July 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

During our inspection we spoke with four people who used the service and one relative. The summary describes what people using the service and the staff told us and the records we looked at. If you want to see the evidence that supports our summary please read the full report.

This is a summary of what we found:

People we spoke with told us they liked the staff. One person said "the cook is exceptionally good, kind and accommodating. Another person said "I get on well with all the staff, we have a laugh". We observed interactions between staff and people who used the service. We saw that staff were respectful, kind and helpful.

Care and support was not always planned or delivered to meet people's individual needs and ensure welfare and safety. We saw that not all care plans were reflective of people's current needs. People had not had their capacity assessed about making decisions or giving consent. We saw that people were given choice about the care and support they received. However some people's choices may put their safety at risk. In this case people must have their mental capacity assessed and proper policies and procedures in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards must be followed.

During our visit we found that the premises were uncomfortably warm. Staff were not able to control the environmental temperature and some people who used the service told us that this was an on-going problem. Not all windows on the first floor were fitted with restrictors and this put some people who used the service at risk.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 16 August 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with four people who used the service and to one relative. They told us they liked the staff that supported them. One person said "I get on well with all the staff, they give me as much time as I need". One person told us how much they enjoyed the meals provided.

We looked at care records for four people who used the service. We saw that care plans and risk assessments had not been updated for some time and were not always reflective of people's current needs. For example, people had their risk of developing pressure ulcers and risk of malnutrition assessed. Risk assessments had not been reviewed for several months despite significant changes to their care and support needs. The care plan for one person stated they could walk with a walking frame. Another record stated that this person was not safe to mobilise and required a hoist.

Some people had cognitive impairment because of their condition. Staff had not assessed their capacity to give their consent to care and support. Some people were resistive to receiving personal care. We spoke with staff about how they ensured that people had their personal care needs met. Staff were unclear about this. This meant that some people may not have had their needs met and this put them at risk.

Two people had left the home unsupervised and had been put at significant risk to their safety. We looked at care records and spoke with staff about how they managed this risk. We found that the planning and delivery of care did not meet individual needs or ensure health and welfare. One person had lost a significant amount of weight. We could not see any evidence of staff taking appropriate action or monitoring this person's food and fluid intake.

We saw written evidence of people being provided with social and recreational activities. However, during our visit people were not offered any activity opportunities. We saw that some people were sitting in silence for a long time either in the dining room or in the lounge. Some people were falling asleep at the dining room table. Some people had their life histories and hobbies and interests recorded in their care records. Other people did not. This information is of particular importance to people who have difficulty communicating their needs and preferences. One person who spent a lot of time in their room because of their health condition told us they did get very bored.

We looked at staffing rosters and spoke with staff about staffing numbers. On the day of our visit there were 16 people using the service. Staffing numbers were short by one care assistant because of short notice staff sickness. Staff we spoke with did not know how the staffing numbers were calculated. They told us that with the current occupancy level staffing numbers were sufficient to meet people's needs. One person we spoke with told us that staff came quickly when they used their call bell. Some people had complex and high dependency needs. We could not see any evidence that people's dependency needs were taken into account when deciding on required staffing numbers. This meant that staffing numbers may not have been sufficient to meet people's needs.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who used the service were not protected against the risks of unsafe or unsuitable premises.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with four people who used the service and to one relative. Two people told us the home was often uncomfortably warm. We checked the provider's wall thermometer and saw that the temperature was 32 degrees centigrade. This was above ambient room temperature. We spoke with the staff about this. They told us they were unable to adjust the temperature of the home and that it was often uncomfortably warm.

We carried out a tour of the premises; we saw that the majority of rooms on the first floor did not have restrictors on the windows. Many of the windows were low and easily accessible to people who used the service. Some people had cognitive impairment because of their health condition. This meant that some people were at risk of falling from a first floor window.
Shortly after our visit the acting manager told us about the immediate actions they had taken to reduce risk for people who used the service. The site estates manager turned down the boiler temperature. The acting manager purchased room thermometers so that daily temperatures could be monitored. Window restrictors were fitted to some of the first floor bedrooms and more were ordered. Increased monitoring of people at risk was commenced.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare. Regulation 9 (1) (b) (I) and (ii)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: People who used the service were not protected against the risks of unsafe or unsuitable premises. Regulation 15 (1).

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 16 August 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

This section is primarily information for the provider

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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