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: 30 September 2014

Date of Publication: November 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✖ Action needed
Safety and suitability of premises	✓ Met this standard

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'.

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Belton House Retirement Home had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Safety and suitability of premises

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 30 September 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 and talked with staff.

What people told us and what we found

We spoke with three people who used the service and two members of staff. People told us the quality of care and support they received had improved since our last visit. We saw that interactions between staff and people who used the service were positive and respectful. We saw that people were able to make choices about how they spent their time and there were more opportunities for social and recreational activities.

We found that care plans and risk assessments had been updated. Records showed that one person was at significant risk of falling. The provider took action to reduce this risk shortly after our visit.

Staffing numbers were not based on the needs of people who used the service. There was not always sufficient numbers of staff on duty to meet people's needs or to keep them safe.

The provider had installed an air conditioning unit in the main hall and we found that the temperature of the service was comfortable. Window restrictors had been fitted on all first floor windows. This meant that the risk of falling from a first floor window had been reduced.

In this report the name of a registered manager appears who was not in post and not managing the regulatory activities at this location at the time of the inspection. Their name appears because they were still a Registered Manager on our register at the time.

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 29 November 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

Our inspection of 6 July 2014 found that care and support was not always delivered in a way that met people's individual needs or ensured their health and welfare. Care plans were not always reflective of people's needs. Risk assessments had not been updated for a long time. This meant that people may not have their needs met, nor were they protected from harm. People who used the service had not had their capacity to make a decision assessed. Some people may not have had the capacity to make decisions about care and support and may have been putting themselves at risk. When this is the case a 'best interest assessment' must be carried out. We also found that people had very limited opportunities for social and recreational activities. Staffing numbers were not sufficient to meet people's needs.

During this visit we saw spoke with three people who used the service. All were complementary about the staff. One person said "The staff are very friendly, we know them, they have time for you".

We looked at care records for three people who used the service. We saw that each person had a plan of care that had recently been updated. Risk assessments had also been updated and appropriate management plans were in place. Staff were in the process of updating people's life history records so that staff had as much information as possible about people's individual needs and preferences. We were informed that an 'activities organiser' had recently been employed and was soon to commence working at the service. People we spoke with told us there were opportunities for recreational and social activities but they would like more.

We looked at records of accidents and incidents. We saw that there were less accidents and incidents recorded since our last visit. We saw that one person had been found outside their room on several occasions during the night. Their room was on the first floor.

This person was at risk of falling including falling down the stairs. We were informed shortly after our visit that this person had moved to a room on the ground floor.

We spoke with the acting manager and to staff about the Mental Capacity Act and associated Deprivation of Liberty Safeguards. We were informed that one person had a DoLS in place. This meant that a best interest decision had been carried out by an authorised person. The person's liberty was restricted in line with this authorisation in order to keep them safe. Staff we spoke with had awareness of DoLS but were not sure who had an authorisation in place. Staff must be made aware of this so that care and support could be provided in the least restrictive way. We discussed the recent Supreme Court ruling about DoLS with the acting manager. The acting manager agreed to consider each person's capacity to make decisions regarding their care and support and to refer people to the DoLS team should this be required.

We spoke with two people who used the service and to staff about staffing numbers. One person said "There are usually enough staff around but at times there are not enough". On the day of our visit there were 15 people using the service. One member of staff was out escorting a person to a hospital appointment and another member of staff was attending a doctor's appointment. This meant that for a short period of time there were only two care staff on duty. We had to wait for 26 minutes for the door to be answered. We were informed that the two staff members were upstairs and could not hear the doorbell. We could see through the glass panels on the front door that a person who used the service was in the corridor and appeared lost. There were no staff available to assist them for a long time. Staff we spoke with told us that this was not a 'typical' day and that there were usually enough staff to meet people's needs and keep them safe.

The acting manager was not aware of how staffing numbers were calculated. There were at least three people who used the service who had high dependency needs and required close observation in order to ensure their safety. Staffing levels were not always sufficient to meet the needs of people who used the service.

Safety and suitability of premises ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

Our inspection of 6 July 2014 found that the temperature at the service was uncomfortably warm. We also found that there were no 'restrictors' on the first floor windows. Some people who used the service had cognitive impairment and were put at risk because of the lack of window restrictors.

During this visit we found that the provider had taken action to address these shortfalls. An air conditioning unit has been fitted in the main hall and window restrictors had been fitted to all first floor windows.

We spoke with three people who used the service. One person said "The air conditioning has made an immense difference to us". We saw that the provider's wall thermometer was recording a temperature of 25 degrees centigrade during our visit. All areas of the service we visited were at a comfortable and ambient temperature during our inspection.

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) (ii) and (ii).

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 29 November 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.

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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