Care Quality Commission

Mr David Arthur Salter

Belton House Retirement Home

Inspection report

Littleworth Lane
Belton in Rutland
Oakham
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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?

Requires Improvement 

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.

Is the service effective?

Requires Improvement 

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.

Is the service caring?

Not sufficient evidence to rate 

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.

Is the service responsive?

Requires Improvement 

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.

Is the service well-led?

Requires Improvement 

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.

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