# Benslow Management Company Limited

# Chiltern View

## Inspection report

198-200 West Street
Dunstable
Bedfordshire
LU6 1NX

Tel: 01582477794
Website: www.benslow-care-homes.co.uk

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

| | |
|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

This inspection took place on 14 September 2016 and was unannounced. We last inspected this service on 11 March 2015 and awarded a rating of 'good' in all of the areas we looked at. We re-inspect the service earlier than planned because we had received concerning information that showed an increase in the number of incidents where people's needs had not been met safely.

Chiltern View is a residential care home that provides accommodation and personal care for up to 36 older people, some of whom live with dementia. At the time of our inspection there were 24 people living at the home.

The home has a registered manager in post. 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.

The service was not always safe because pressure care for people who needed it was not always provided in a timely way. People's medicines were managed and stored appropriately and the provider had robust policies in place for the safe recruitment of staff. Staff were trained in safeguarding people and people had individualised risk assessments in place that gave guidance on keeping them safe.

Adaptations of the home environment had been made in order to meet people's needs. Staff recognised people's care needs and were trained to meet them. They understood their responsibilities to seek people's consent before providing care in line with the requirements of the Mental Capacity Act 2005. They supported people to access healthcare services when required.

People were cared for by staff that were friendly, kind and caring. They supported people in ways that promoted their privacy, dignity and respected their views. They provided the support that was personalised to people and with support from the management team, they ensured people's complaints and concerns were resolved. The registered manager, with support from the provider, ensured the service ran appropriately providing visible leadership and oversight at all levels.

## 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 always safe.

Pressure care for people who needed it was not always provided in a timely way.

People's medicines were managed and stored appropriately.

The provider had robust policies in place for the safe recruitment of staff.

Staff were trained in safeguarding people and knew how to keep people safe from avoidable harm.

People had individualised risk assessments in place that gave guidance on keeping them safe.

### Is the service effective?

**Good**

The service was effective.

Adaptations of the home environment were made in order to meet people's needs.

Staff were trained to meet people's care needs.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were met.

People were supported to access healthcare services when required.

### Is the service caring?

**Good**

The service was caring.

Staff were caring, supportive and respectful towards the people who lived at the home.

Staff had developed positive relationships with people.

People were supported to maintain relationships with their

relatives and had their privacy and dignity respected.

## Is the service responsive?

Good

The service was responsive.

People's care needs were identified before they moved to the home and the appropriate care plans were put into place.

People were supported in a personalised way.

There was an effective system in place for handling complaints.

## Is the service well-led?

Good

The service was well-led.

There was a registered manager in post.

Both the registered manager and the provider were visible and approachable.

The provider had systems in place for monitoring the quality of the service provided.

# Chiltern View

**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 on 14 September 2016 and was unannounced. It was carried out by one inspector from the Care Quality Commission (CQC) and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of caring for people who used regulated services such as this one.

Before the inspection, we reviewed the completed Provider Information Return (PIR) which the provider had sent to us. The PIR is a form that asks the provider to give some key information about the service such as, what the service does well and improvements they plan to make. We also reviewed the service's previous inspection report and information we held including notifications. A notification is information about important events which the provider is required to send us by law.

During the inspection, we spoke with five people who used the service, and five relatives of people who used the service to gain their feedback on the quality of the service. We also spoke with two members of the care staff, the activities co-ordinator, the cook, a member of the house keeping staff, the provider's regional manager and the registered manager.

We observed how care was delivered and 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. We reviewed the care records and risk assessments for three people, checked medicines administration records and reviewed how complaints were managed. We also looked at three staff records and reviewed information on how the quality of the service was monitored and managed.

Following the inspection, we spoke with the local authority's contracts monitoring team who carried out regular audits of services, to gather feedback about this service.

Requires Improvement

# Is the service safe?

## Our findings

Before this inspection we received information that showed an increased number of safeguarding related incidents at this home. These incidents were in relation to people's care needs around pressure ulcers not being met safely, and that a person who lived at the home had left the home without staffs' knowledge when they had protective measures in place to prevent them from going missing.

We found that the provider was taking corrective action to address the concerns raised. For example, an investigation was carried out to determine how a person went missing from the home and measures were put in place to reduce the chances of it happening again. More frequent checks of people had also been introduced to ensure everyone was accounted for. The provider's operations manager told us that there were plans to replace the gate with a fence panel as the gate was never used.

In relation to people who required pressure care, we found that the provider had a system in place to monitor and record people's nutritional intake, and how often they were repositioned. These were recorded on 'turns' and 'food and fluid' charts. We reviewed these charts and found that although they were completed, they were not always coherent. This was because the provider had adapted a new computer system for recording and storing information pertaining to people's care, and they were in the process of migrating to this system. The deputy manager told us that people's pressure care was delivered appropriately but there was a recording issue. They said, "Sometimes the iPads freeze so staff would record checks on paper and some staff have not fully understood the iPads yet so they would record on the paper copy." Having reviewed both the electronic and paper copies of people's food, fluids and turn charts, we found that in the main people were repositioned within planned times. There were however times when turns were over two hours overdue. This heightened the risks associated with pressure ulcers to people who were already at risk.

There was a strong smell of stale urine which was present from the front entrance to the home and throughout. The deputy manager told us, "It is because one of our gentlemen chooses to urinate in the communal areas rather than in the toilets." A member of the house keeping staff corroborated what the deputy manager told us. We observed the housekeeping member of staff using a carpet cleaning machine to clean the carpets in the communal areas. The registered manager told us about this issue, "We have carpets because we wanted to promote a homely feel to the place but because one of our gentlemen urinates on the carpets, we have agreed plans to remove all the carpets in the affected areas and replace them with more suitable flooring." In further discussions with the registered manager and the operations manager, they told us that they were exploring long term solutions which included reviewing the person's history in order to determine why this behaviour was presented, and then put in place the correct care plan to support them.

Other parts of the home which included some people's bedrooms and toilets were not particularly clean. There was a team of housekeeping staff who had a day to day cleaning program. The deputy manager informed us that there was usually two housekeeping staff on everyday but there was only one on the day of our inspection due to annual leave, and that the one member of the team on shift was in the process of

completing the required cleaning tasks. We observed that this cleaning was ongoing for the duration of our inspection and had improved, although not totally eliminated the odour of urine within the home.

People were supported by staff with the management and administration of their medicines. A person we spoke with told us, "Yes, staff help me with my medicines." A relative of a person who used the service said, "We don't have any concerns with medicines. [Relative] has cut right back now [on medicines], but the ones that [they] still have are given to [them] by staff." Medicines were only administered by staff who had been trained to do so. Medicines were stored securely in a designated storage area within the home.

The provider told us on their Provider Information Return (PIR) that they were going to adapt a computerised system for managing and administering people's medicines in order to reduce the risk of errors. This meant that people's medicines administration records (MAR), and other medicines related information including times that medicines were to be taken, were all stored on a laptop computer. The system only allowed authorised staff to access and administer people's medicines at pre-programmed times. Once these times had passed, the system would not allow medicines to be administered. For example, the morning medicines round was programmed to take place from 8am to 11am, and if staff had not administered people's medicines programmed to be given within that time, the system would record the medicines as 'not administered'.

We found two occasions where a person choose to remain in bed until after 11am which was the cut off time for the morning medicines round. The staff sought advice from the pharmacist who reportedly told them to administer the person's medicines once they had woken up, and to print a copy of the MAR chart and sign it to state they had administered the medicines. We discussed the implications of not administering people's medicines at the prescribed time with the operations manager and the registered manager. They agreed to arrange a medicines review with the person's prescriber to formally determine an appropriate time for the person medicines to be administered. We checked three other people's medicines against their medicines administration records (MAR) and found that they had been completed correctly.

People who used the service and their relatives told us they felt there were enough staff to meet people's needs. One person told us, "Yes, there is enough staff, there is always staff here." A relative said, "There is enough staff yes, they act on issues quickly." Staff's views on the subject were similar. The registered manager told us of the provider's blanket policy around staffing levels. They said, "There is a ratio of one to five." This meant that there was one member of the care staff allocated to every five people who lived at the home, and as there were twenty-four people who lived at the home at the time of our inspection, there were five members of the care staff during the day time and two members of staff at night.

We noted during our inspection that staff rushed around and appeared to be under pressure while they supported people. The lunch time routine for example, which involved supporting some people to eat and drink, started at 1pm when people took their seats in the dining area and went on till 1:54pm and some people still hadn't received their meals. This amongst other similar observations indicated that the staffing levels were not always adequate. We raised this with the registered manager and the operations manager. They agreed to review the staffing levels taking into account the needs of the people who lived at the home. They agreed to increase the number of staff for the morning shift with immediate effect.

We also found that there were staff vacancies which the deputy manager told us were covered by staff working extra shifts where possible, and when necessary they used agency staff. The registered manager told us that a recruitment drive had taken place and that the staff vacancies had been filled. The potential new members of staff were going through the provider's pre-employment process.

There were robust recruitment and selection processes in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. We looked at three staff files and found that appropriate checks had been carried out before they began work at the home. These included identity and employment history checks. The provider also obtained references from previous employers and completed Disclosure and Barring Service (DBS) checks. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed.

People and their relatives told us people were safe living at the home. One person said, "Yes I'm safe." When asked what made them feel safe they said, "Well I'm sitting here and the people [staff] make me feel safe." Another person told us, "It is very safe here, the whole atmosphere is safe." A relative said, "Goodness me yes, it is safe here. Staff are always around to keep them [People] safe."

The provider had up to date safeguarding policy that gave guidance to the staff on how to identify and report concerns they might have about people's safety. Staff were trained and they demonstrated a good understanding of different types of abuse and the signs that could indicate that someone could be at risk of possible harm. They were able to tell us which external organisations they could report concerns to. A member of staff told us, "We would report any safeguarding [concerns] to social services and the safeguarding team." In addition the provider had a whistleblowing policy that provided staff a way in which they could report concerns within their workplace without fear of doing so. Staff were aware of these policies and understood their responsibilities within them.

People had personalised risk assessments which formed part of their care plans. These risk assessments detailed the hazards that had potential to cause harm to people, and gave guidance to staff on minimising risks. We looked at three people's risk assessments and found that they were clear and up to date. One person's was due to be updated and the registered manager told us that would be completed once that person was discharged from a hospital admission that was ongoing. Staff were aware of people's risk assessments. A member of staff told us, "The managers tell us about any changes to risk assessments. We also tell the managers if we notice any changes to risks affecting them [People]."

The provider had also carried out health and safety risk assessments to manage risks posed to the people by the home environment. These covered areas such as clinical waste management, slips, trips and falls, medicines management and gas safety. They gave clear guidance to staff on managing risks. In addition, each person who lived at the home had a personal emergency evacuation plan that provided guidance to staff on supporting people to evacuate the premises should an emergency occur. There were contingency plans in place to manage emergency events such as electrical failure or adverse weather conditions, to ensure that people were kept safe.

Good

# Is the service effective?

## Our findings

We found that parts of the home including some toilets and communal areas needed to be renovated. The registered manager and the deputy manager told us of the provider's extensive plans to refurbish these areas. The refurbishment plans included replacing carpets and adding windows in the ground floor hallway, and replacing flooring in the ground floor bathroom. The registered manager told us that the planned work was going to be started on the week following our inspection of the service.

The décor in the lounge area and corridors were of a 1960s and war time theme with military memorabilia such as helmets and belts hung on the walls. The registered manager told us that this was to stimulate memories for people who lived with dementia and make them feel at home. They said, "We had the Prince's trust here and they did the military style themed area for us to trigger memory. [People] relate to it and every now and then someone would walk past and go 'I remember this' and it starts a conversation." This showed that the provider had taken steps to adapt the decoration of the home in order to meet people's needs.

People were not able to fully give their views on the effectiveness of the service however, their relatives told us that staff were knowledgeable in their roles. One relative said, "I am very impressed with [Relative's] care, the staff know [them] very well. [They] were down when [they] first came here but a lot happier now."

Evidence we looked at showed that staff had received an induction when they started working at the home. Staff told us that this included meeting people who used the service and the staff team, undertaking required training, reading people's care plans, and being mentored by more experienced staff. We found that staff had received the necessary training to equip them for their roles. One member of staff told us, "The training is very good. It makes you understand how to care for the ladies and gentlemen [People]." A relative added, "I'm not sure what training they do but I have seen to [staff] caring for the [people] and they are very good." Staff training covered areas such as safeguarding people, medicines management and dementia care. Regular refresher courses were undertaken to ensure staff training was up to date. We noted that nearly all the staff had gained further qualifications in care, such as National Vocational Qualifications (NVQ) and Qualification and Credit Framework (QFC).

The registered manager told us that they carried out annual appraisals of staffs' performances and regular staff supervisions as a way of supporting staff. A member of staff we spoke confirmed this and said, "I have my supervision every other month. We discuss any staff issues, training and any issues affecting [People]." We noted that the registered manager had developed a matrix that they used to monitor the frequency of staff supervisions. A review of this matrix confirmed staff supervision and appraisals were up to date.

We saw that staff communicated with people effectively. Staff told us that they used body language and other non-verbal forms of communication to understand the needs of some of the people who, due to their healthcare needs, could not communicate verbally. For example we saw that staff recognised people's behaviour and mannerisms to understand when they needed assistance with personal care. We also saw that staff sought people's consent before providing care or support. For example, we observed a member of staff approached one person who was sitting down in the lounge, bent over so that the person could see

easily, and asked them if they were happy to be supported to the dining room for their meal. The person consented and the member of staff proceeded to support them.

Staff had received training and they understood the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards (DoLS). 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.

Staff demonstrated a clear knowledge of their responsibilities within the Act. We saw evidence that people's capacity to make and understand the implication of decisions about their care were assessed and documented within their care records. The registered manager showed us the provider's revised framework for assessing people's mental capacity and for making best interest decisions which was a clear improvement from the previous one.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The management team had assessed whether people were being deprived of their liberty due to the way their care was managed. They found that authorisations were required for some people and therefore applications had been made to the supervisory body as required by the MCA.

People told us that they had enough to eat and drink. One person said, "Yes, I enjoy the food." A relative of a person we spoke with told us, "The food always looks good and they make sure [Relative] has regular drinks especially in this hot weather." We saw that people had care plans around eating and drinking. This contained their preferences around food and drinks and any support they required from staff. They also contained information about the outcomes people wanted around nutrition. For one person this was for the home to ensure that they had a nutritious well balanced diet and that staff monitored their weight. Also, they wanted their rights and choices around food and drinks respected. We saw that this person's weight was monitored and they were offered choices at meal times.

A relative we spoke with told us that, "[Relative] has definitely put on weight since coming here." We saw that where people required support to eat their meals this was provided by staff and that people were offered hot drinks and snacks throughout the day. We noted that staff checked what people wanted for their lunch, which was a selection of two set meals. If they did not like what was on the menu then an alternative was offered.

People were supported to access a range of health and care services in order for them to maintain their health and well-being. A relative we spoke with told us, "They [staff] are quick to call a doctor if [Relative] ever needed one". We reviewed people's records showed that people had obtained support from professionals such as, GPs, district nurses, and dentists as appropriate to their needs. We saw that people's health conditions were recorded in their care plans together with the support they required from staff or healthcare professionals and outcome of treatments.

Good

# Is the service caring?

## Our findings

Staff were caring, supportive and respectful towards the people who lived at the home. A person we spoke with told us, "Everyone is really friendly and helpful." Another person said, "They're very kind here." A relative we spoke with added, "Staff are fantastic, I only visit once a week but [Relative] is always clean, [their] personal hygiene is better than what it was at home."

Staff had developed positive relationships with people who lived at the home. They were aware of people's life histories, their likes, dislikes, hobbies and interests which were well documented within their care records. This enabled staff to provide care that was centred around each person who lived at the home. We saw that staff interacted with people in a friendly and respectful way and called them by their preferred names.

People's relatives told us that staff listened to people's views and respected their wishes. A relative we spoke with was full of praise for the staff, they told us, "I like the fact that they [staff] are very personable and do what we ask them." Staff respected people's privacy and dignity. A member of staff we spoke with described ways in which they protected people's privacy and dignity, such as making sure doors were closed during personal care. We saw that they knocked on people's doors before they went into their rooms and kept doors closed when they provided personal care to people. Staff also understood how to maintain confidentiality by not discussing people's care needs outside of the work place or with agencies that were not directly involved in people's care. We also saw that people's care records were kept securely in the manager's office or on the new computer system.

Staff understood the importance of promoting peoples independence and this was documented throughout the care records. We saw staff patiently encouraging people to do as much for themselves as they could and stepped in to support where necessary. For example during lunch time, we saw staff encourage a person to help themselves with small amounts of food and drink, but were prepared to offer assistance where this person struggled.

People's relatives and members of the staff team told us that there were no restrictions on visiting times and that people's relations and friends could visit at any time. A relative told us, "No there aren't any restrictions on the time we can visit. We just come whenever we like." We observed a number of people's relatives visiting and spending as much time as they wished with people. This enabled people to maintain the friendships and relationships that they had before they came to live at the home.

There was a noticeboard displaying photographs of the staff who worked at the home so people and visitors could identify them. People were also provided with information about the home which included the services they offered and who they could complaint to if they wanted to. Some people's relatives or social workers acted as their advocates if they were unable to do this by themselves. Others had support from advocacy services to ensure they understood the information given to them and that they received the care they needed.

Good

# Is the service responsive?

## Our findings

People who used the service had a variety of support needs that had been assessed prior to them being supported by the service. This was confirmed by relatives we spoke with. One relative told us, "We met with the manager and talked through [Relative's] care, what they liked and didn't like." The assessment of people's needs covered areas such as their activities of daily living, cognitive abilities, their dietary needs and preferences, social interaction, interests and hobbies. They formed the basis from which people's care plans were developed.

Personalised care plans were put in place so that people received care that appropriately met their needs. Staff were aware of people's care plans which included clear instructions for them on how best to support people. There was clear evidence that the care provided was person centred and that the care plans took account of people's needs, choices and preferences. They were reviewed regularly with involvement from people and their relatives. We saw that the provider had adapted a new electronic data management system where people's care records were to be held. They were in the process of transferring all care plans to this system. The operations manager told us that this system was going to have a relatives' 'gateway' so that relatives could access care plans and keep up to date with how their relatives were being cared for.

People were supported to maintain their hobbies and interests. The provider had employed an activities coordinator who researched and supported people to take part in suitable activities. We saw that activities planned for the week that our inspection took place included leg exercises, outing for afternoon tea and knitting or taking part in maintaining life skills such as dusting and hoovering. There was an activities board showing the planned activities for the week on display, and photographs of past events, including celebrations of a person's birthday, were displayed on picture boards to remind people of them. The activities coordinator also told us of the gardening activities that included growing plants during the warmer months. A relative we spoke with told us, "They do lots of activities, the only thing is I wish they [staff] will take them [people] out more or even use the garden more."

The provider had a complaints procedure in place and the people were spoke with and their relatives told us they knew who they could raise concerns to. One person said, "I would tell staff," when we asked if they knew who to raise concerns with. A relative we spoke with told us, "I have no complaints, they keep [Relative] nice and clean and keep me updated of any changes. If I had complaints I will talk to the manager." We reviewed the records of complaints that had been made and found that they were resolved to complainants' satisfaction.

Good

# Is the service well-led?

## Our findings

There was a registered manager in post. They were supported by a deputy manager and the provider's operations manager. People and their relatives knew who the registered manager was and commented positively about them and the provider. One person told us, "Yes I know the manager." A relative said, "[Registered Manager] is very good, she always communicates with our family about any changes that are happening." Another relative told us, "The place is very well managed, they don't try to cover anything up."

We saw that the registered manager was visible and had a clear understanding of the needs of the people who used the service, their relatives and staff. Staff told us that the management team were approachable and supportive of them. A member of staff we spoke with said, "[Managers] are very supportive. [Registered manager] has an 'open door policy'. You can talk to [them] about anything."

We found the manager to be clear about their role and responsibilities, and were in tune with what was going on in the home. They were positive about the support they received from the provider and told us, "The provider visits often and rings up even at weekends. If we need him for anything we just ring him and he will come in." We found that the provider visited the home at least once a month and the operations manager visited every week. Together with the registered manager they provided a visible leadership for the home.

Staff were also aware of their role and responsibilities. They were able to demonstrate a good understanding of the provider's visions and values, which included ensuring that people were happy, getting a good service, were well cared for and promoting their independence. Bimonthly team meetings were held which gave the staff team the opportunity to collectively discuss issues in relation to the people who used the service and their work. We reviewed the minutes of the staff meeting that took place in July 2016 and found that the topics of conversation included the use of mobile phones, cleanliness of the home which was highlighted by the operations manager during an audit, time keeping and staff training. These meetings also gave staff the opportunity to be involved in the development of the service.

Two monthly meetings involving people who used the service were also held as a way of involving them in the development of the service. This enabled people to discuss issues that affected them and the care they were provided. Records from a recent meeting showed the main areas of discussion to be activities and menus.

The provider sent out satisfaction survey questionnaires to a revolving number of people, their relatives, healthcare professionals and staff on a monthly basis. These were collated over the year and were used to understand the areas of the service that required improvement. We reviewed the results of the satisfaction surveys from 2011 to 2015 and found a sustained level of satisfaction.

There was an effective quality assurance system in place. Quality audits completed by the registered manager, the operations manager and the provider covered a range of areas including people's care plans and medicines management, health and safety, staff supervision and complaints. We saw that action plans

had been developed where shortfalls had been identified and the actions were signed off when they had been completed.

The provider also had a system for handling and managing compliments that were made about the home, the staff and the care that was provided to people. We reviewed records of compliment and found one that read, "Thank you for the special care you have given my [Relative]. As a family we are eternally grateful to you for being so understanding and kind."