Benton Care Limited

Benton House

Inspection report

Gattison Lane
New Rossington
Doncaster
South Yorkshire
DN11 0NQ

Tel: 01302863188
Website: www.selecthealthcaregroup.com

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

The inspection took place on 14 March 2017. The inspection was unannounced.

Benton House is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Benton House provides accommodation and support for up to 34 older people. There were 26 people living at the service at the time of our inspection. People had varying care needs. Some people were living with dementia, some people had diabetes, some people required support with their mobility around the home and others were able to walk independently.

The service was in a detached building in a residential area. A private garden was available for people to sit out in when the weather was fine. Bedrooms were on the ground and first floors. A passenger lift was available between floors so people could access any part of the building if they wished.

At the last inspection in December 2015 the service was rated Good. At this inspection, we found the service remained Good.

There was a registered manager who had been in post approximately four months. A registered manager is a person who has registered with the Care Quality Commission 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.

There were arrangements in place to keep people safe and to help safeguard people from the risk of abuse. Staff understood their responsibilities for safeguarding people from harm and followed the registered provider's policy and procedure. Systems were in place to identify potential risks associated with people, the environment and equipment. Medicines were stored appropriately and kept at a suitable temperature, including controlled drugs needing additional security. Medicine records (MARs) were well kept and legible. Recruitment procedures were thorough and ensured there was sufficient evidence of the applicant's suitability before staff were confirmed in post. There was sufficient staff available to meet people's needs safely.

People's needs and choices continued to be assessed when they started using the service. People received care that was personalised to their needs. People were encouraged to raise concerns or complaints and were asked for feedback about the service they received.

People were supported to make their own choices and decisions whenever possible. The registered manager and staff continued to have a good understanding of the basic principles of the Mental Capacity

Act 2005 (MCA) and promoted people's rights.

People were involved in their care. Care plans were personalised and reflected people's current needs and preferences. They contained the information staff needed to provide people with the care and support they wanted and required. There continued to be clear evidence of the caring approach of staff. People and their relatives were positive about the staff who supported them, describing them as caring and saying they were confident in the care they received. Staff knew people well and were able to respond to their needs on an individual basis whilst treating people with respect and upholding people's dignity.

The service had an open and positive culture that encouraged involvement of people, their families, staff and other professional organisations. Leadership was visible and promoted teamwork. Staff spoke positively about the service and had a clear understanding of their roles and responsibilities. Audits and quality assurance processes were in place to identify areas of service improvement. The service understood their legal responsibilities for reporting and sharing information with other services.

Further information is in the detailed findings below.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Benton House

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 registered 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 February 2018 and was unannounced. The inspection was undertaken by one adult social care inspector.

Before the inspection the provider completed a Provider Information Return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We received the completed document prior to our visit and reviewed the content to help focus our planning and determine what areas we needed to look at during our inspection.

We also reviewed other information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

We spoke with three people who lived at the service and one relative to gain their views and experience of the service provided. Some people living in the service were not always able to articulate their views or had a poor memory although we spent time in communal areas observing the care and support provided and the interaction between staff and people. We also spoke to the registered manager, and five staff. We also received feedback from one healthcare professional.

We looked at six people's care files, medicine administration records, four staff recruitment records as well as staff training and supervision records, the staff rota and staff team meeting minutes. We spent time looking at the provider's records such as; policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at residents and relatives meeting minutes and surveys.

Good

Is the service safe?

Our findings

People continued to receive a service that was safe.

Some people living in the service were not always able to articulate their views or had a poor memory. However, the people we did speak with told us they felt safe living at Benton House and with the staff who provided their care. One person said, "I feel very safe. I know there are staff here to help me when I need them." A relative told us, "I have been coming here for years and have never had any concern around the safety of my relative or any other person."

Staff were knowledgeable about safeguarding adults from abuse. They told us about the action they would take to protect people if they suspected they had been harmed or were at risk of abuse. They knew that they needed to report any concerns to the registered manager and when appropriate to external agencies including the local authority safeguarding team. Staff training records showed that staff had received training in safeguarding people.

Recruitment procedures were thorough and ensured there was sufficient evidence of the applicant's suitability before staff were confirmed in post. There was sufficient staff available to meet people's needs safely. People said they felt safe because there were enough staff on duty who knew how to support them. For example one person said, "When I ring the bell they always come quickly."

Risks to people's safety were assessed before, and whilst receiving care from the service. Risks to people were identified and risk management plans were in place to minimise and manage the risks and keep people safe. These protected people and supported them to maintain their freedom and independence. Some people had restricted mobility and information was provided to staff about how to support them when they moved around the home. Risk assessments included areas, such as falls, fire safety and choking. Care staff we spoke with were aware of people's risk assessments and the guidance that they needed to follow to protect people from harm.

Records showed us that staff had completed training on infection control. Protective clothing including disposable gloves and aprons were used by staff when undertaking some tasks, to minimise the risk of cross infection. 'Spot checks' carried out by the registered manager of care staff providing people's care included checks that their practice minimised the risk of infection.

Medicines were stored appropriately and kept at a suitable temperature, including controlled drugs needing additional security. Medicine records (MARs) were well kept and legible. Systems had been adopted to reduce the risk of errors, including photographs of each person receiving support with their medicines and information regarding known allergies. We found some instances of liquid medication which did not have an 'opened on' date recorded. We discussed this with the registered manager who told us they would address this at a team meeting and through individual staff supervision.

The registered manager completed an audit of accidents and incidents each month. They analysed any

incidents for themes to prevent avoidable re-occurrence. They also checked that appropriate action and follow up was taken.

Staff we spoke with demonstrated a good understanding of their roles and for infection control and hygiene. One staff member told us, "We always have a supply of hand sanitiser, gloves and aprons. Records showed that staff responsible for preparing and handling food had also completed food hygiene training.

Good

Is the service effective?

Our findings

People continued to receive a service that was effective.

Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs and the actions staff needed to take to support people. People and their families were involved in discussions about their care needs and had their life choices respected. Care was delivered in line with current legislation and good practice guidance. Technology and equipment was available that increased people's independence and safety. Examples included sensory alarm mats for people at risk of falls, hoists for assisting with transferring people and a call bell system that enabled people to call for assistance when needed.

Staff new to the service were provided with a period of induction, and were expected to complete the Care Certificate. This is an identified set of standards that health and social care workers adhere to in their work. New staff were observed by senior members of the team to ensure they were competent in their role. Individual and group supervisions were carried out to support staff in their roles.

Records confirmed staff training included, Mental Capacity Act 2005, fire safety, safeguarding, dementia, end of life care. Staff files showed training was kept up to date which meant staff were equipped with current guidance to put into practice. In addition to this the registered manager carried out competency checks to determine how staff applied the learning gained. Clinical training for registered nurses was routinely undertaken to maintain the necessary skills to meet the needs of the people they cared for. The service followed best practice in end of life care.

People's dietary needs and preferences were documented and known by staff. Some people had special dietary needs and preferences. For example, people having soft food or thickened fluids where choking was a risk. Staff assessed and monitored people's risk of malnutrition and dehydration and contacted GP's, dieticians, speech and language therapists (SALT) if they had concerns over people's nutritional needs. Where people were identified as being at risk of malnutrition, a malnutrition universal screening tool (MUST) was used to assess, monitor and manage this risk. Records showed people's weight was maintained.

Staff supported some people to access healthcare appointments if needed and liaised with health and social care professionals involved in their care if their health or support needs changed. This included healthcare professionals such as GPs, dentists, district nurses and community psychiatric nurses (CPN) to provide additional support when required. Care records showed staff shared information effectively with professionals and involved them appropriately. A CPN told us, "Communication with the home and staff is very good and they are responsive to any suggestions or changes I may advise for people."

The home's environment was pleasant and areas such as the lift were regularly serviced, but there were areas of the home which were described by the registered manager as, 'looking tired'. The registered manager had only been in post for four months but had begun to produce a programme of redecoration.

They told us that redecoration would involve contrasting colours in the furnishings floor and wall coverings. This contrast helps people with sensory loss navigate their surroundings and can help reduce the risk of falls. There was an accessible garden which people told us they enjoyed using in the good weather.

Consent to care and treatment was sought in line with legislation and guidance. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA. We found that systems were in place to assess peoples' capacity to make decisions about their care, and DoLS applications had been completed where appropriate. These referred to people's care records and potential areas that could be viewed as restrictive in order to keep someone safe, such as the use of bed rails.

We saw staff consistently encouraging people to make their own decisions and seeking their consent before providing care and support.

Good

Is the service caring?

Our findings

People continued to receive a service that was caring.

People told us they received care and support from staff who were caring, compassionate and kind. One person told us, "The staff are lovely." Another person said, "It's a nice place with nice people, I'm very happy here." A relative commented, "The staff are always kind and friendly, my husband is taken great care of." Throughout our inspection, we observed many positive and caring interactions between staff and the people they were supporting, and we saw warmth and affection being shown to people. The atmosphere was calm and pleasant. There was chatting, laughter and use of appropriate humour throughout the day.

There was an unhurried atmosphere in the home that allowed people time to make their way around the home and supported their independence. We observed all staff showing affection throughout their interactions with people. They were friendly and warm in their conversations with people, crouching down to maintain eye contact and touch to communicate. People were cared for by care workers who knew their needs well. For example, offering snacks to try and tempt a person whose appetite was poor.

People were treated with dignity and respect. Staff showed their respect to people living at the home by their practice. For example, we saw staff knock on a bedroom door and say 'can I come in?' Staff asked people's opinions and included them, rather than just carrying out a task. One person told us "I like to do as much as I can in the bathroom and only ask for help when needed." People told us they had a choice of having a male or female staff member help them with personal care, and that this choice was respected.

Staff were familiar with the specific needs of the people they cared for and could describe how they met people's individual care and emotional needs. People's social history had also been recorded in their care plan. This gave a 'pen picture' of a person's life history, their interests, likes and dislikes, activities or interests that they had enjoyed. We saw staff used this information as a prompt when communicating with people whose memory and communication skills may be deteriorating. For example, discussing past events and significant people.

Good

Is the service responsive?

Our findings

People continued to receive a service that was responsive.

People had their needs assessed before they came to live at Benton House. A member of the management team visited the person, and involved them and their relatives in planning care. The registered manager explained that as well as assessing if the service could meet the person's needs, they also ensured the person's choices were considered and assessed the impact of their admission on the rest of the service before proceeding. We found evidence that these assessments had been carried out in people's care files.

Staff had a handover at the beginning of each shift to update them on changes to people's well-being or health, as well as the needs of new people moving to the service. During our inspection, we saw staff were quick to pick up on changes to people's health and well-being. They worked as a team and kept each other up to date.

People's care records contained detailed information about their health and social care needs. Care plans reflected each person as an individual and their wishes in regard of their care and support. For example, people's preferences about what time they preferred to get up, how they communicated and how to communicate with them, or what food they liked to eat. People and relatives confirmed they were involved in planning their care.

Care plans continued to be reviewed on a regular basis detailing achievements or changes since the last review and confirming the continued effectiveness of the plan or if changes were required. One person's care plan showed their health had deteriorated and changes needed to be made to their care. For example, they now required two staff to support them at all times rather than one member of staff. Care plan reviews were clearly responsive to people's changing needs to make sure staff had up to date information to be able to provide the care people needed and wished for. Staff had recorded in one person's review they had fallen. A referral was made to the falls team to get early advice and intervention to support them to maintain their health and well-being.

People had some opportunities to take part in activities. Although we observed people playing board games, reading the daily papers and sitting chatting with staff, other activities were currently limited. The registered manager was in the process of recruiting a new activities co-ordinator. They told us, "I am about to make an appointment that will restore the level of activities to where we all want it to be." We saw some external people were advertised to attend the home. These included a singer and an interactive session with animals. Some people chose to spend most of their time in their room. One person told us, "I can keep busy with the TV, radio and a good book."

There was a complaints procedure in the service should people wish to raise concerns. This was displayed in the main reception area. The registered manager kept a 'central complaints register'. This would list the details of any complaints received and actions taken. One person told us, "I have no complaints whatsoever." A relative said, "I have no complaints but if I did I am confident the manager would sort it out."

Arrangements were in place to support people at the end of their life to have a comfortable, dignified and pain free death. Records showed that staff involved people and their families in making decisions about end of life care in advance, in order to establish their wishes and preferences, should the need arise in the future.

Good

Is the service well-led?

Our findings

People continued to receive a service that was well led.

Findings from this inspection showed that the home has sustained a positive culture that was person centred, open, inclusive, and which achieves good outcomes for people.

Since our last inspection, the home had a new registered manager in post. Having previously worked at the home they were able to provide consistency for the home in terms of their knowledge and leadership.

A registered manager is someone who is registered with the Care Quality Commission. 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 a service is run.

The staff we spoke with understood and shared the culture, vision and values of the service and its objective to provide high quality care. The registered manager demonstrated a caring approach to their role. They had oversight of the service and worked closely with the area manager and other registered managers within the organisation to adopt a 'lessons learned' approach which supported continual improvement. Staff told us that they felt supported and reassured by the registered manager's presence in the service. A staff member told us, "The manager is very effective." Another said, "I can speak with the manager about anything at any time, they are 100 percent supportive."

There was an open and supportive culture in the service. The registered manager ensured that staff were encouraged and supported, and were clear on their roles and responsibilities and how they contributed towards the vision and values of the service. Staff told us they were encouraged to speak up and contribute in staff meetings which were held regularly in the service. One staff member said, "I genuinely feel our opinion is valued."

A range of audits were in place to monitor the quality and safety of the service provided. The areas checked included; people's care plans, medicines management, maintenance, health and safety, falls, accidents and incidents and infection control. We discussed with the registered manager that the last medication audit had not identified the lack of 'opened on' dates for liquid medication. They assured us that immediate action would be undertaken to address this shortfall. The registered manager also made a 'walkaround' of the service looking at specific areas such as, cleanliness and dining. Following this there was a meeting with staff responsible for care, catering, maintenance and housekeeping to discuss findings or issues identified.

Resident's and relatives meetings were advertised to be held monthly. Also advertised was a weekly, registered manager's surgery.

The registered manager had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner. The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes

to their regulated services or incidents that have taken place in them.

The provider had a whistle blowing policy in place that was available to staff across the home. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy.