Norfolk County Council

NCC First Support - Benjamin Court

Inspection report

Benjamin Court
Roughton Road
Cromer
Norfolk
NR27 0EU

Tel: 01263511856

Date of inspection visit:
19 February 2019

Date of publication:
05 June 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: NCC First Support- Benjamin Court is a care home service. It is registered to provide personal and nursing care for up to 18 people. At the time of our inspection 16 people were living in the service.

People's experience of using this service:

Risks relating to people's nutritional intake were not managed appropriately.

There were no effective systems in place to consistently monitor and assess the safety and quality of service being delivered.

Staff had not completed all of their required training and there was no additional training in mental health available to staff.

Notifiable incidents were not reported in line with the regulations.

Medicines were not always being managed in line with current practice.

Staff had a good understanding of safeguarding people and there were safe recruitment practices in place for new staff.

There were consistently enough staff to meet people's needs and staff were quick to respond to people.

People spoke positively about their care and how the service was run. Staff treated people in a respectful way.

People were given the opportunity to engage in activities of their choosing.

Staff worked in partnership with other agencies and links were forged and maintained with the wider community.

More information is in the full report.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to Meeting nutritional and hydration needs, Good governance and Staffing. We also found one breach of the Care Quality Commission (Registration) Regulations 2009 relating to Notification of other incidents.
Rating at last inspection: This is the first inspection of this service.

Why we inspected: This was a planned inspection based on the service having been registered for one year.

Follow up: We will continue to monitor the service in line with our schedule for services with a requires improvement rating.

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

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

NCC First Support - Benjamin Court

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of two adult social care inspectors.

Service and service type:
Norfolk First Support- Benjamin Court is a 'care home'. People in care homes receive accommodation and nursing or 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. Norfolk First Support- Benjamin Court can accommodate up to 18 people, 16 people were living in the service at the time of our inspection.

People are referred to this service after a stay in hospital or from their home for a period of reablement. Typically, people spend two to three weeks at the service but people can stay for up to six weeks.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

What we did:
Before the inspection we reviewed the information that we held about the service and registered provider. This included any notifications and safeguarding information that the service had told us about. Statutory notifications are information that the service is legally required to tell us about and include significant events such as accidents, injuries and safeguarding notifications.

During the inspection we looked at six people's care files, three staff recruitment files and a range of documents relating to the day to day running if the service. We also spoke with three people who lived in the service, the county manager, registered manager, two members of staff, the activity coordinator, a member of kitchen staff and one healthcare professional.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Learning lessons when things go wrong

- Accidents and incidents were not recorded fully. We saw that whilst the initial incident was recorded, there was no further information about what action was taken as a result of the accident.
- No analysis of accidents or incidents took place, therefore there was no opportunity to take any learning from these events.

Assessing risk, safety monitoring and management

- Risks relating to people's individual care needs were not adequately identified and planned for.
- Where risks had been identified relating to an individual's care, these were not consistently monitored.
- There were personal emergency evacuation plans in place for each person which detailed what support people required to safely evacuate the building.
- Regular fire drills took place and firefighting equipment was maintained well.
- Moving and handling equipment and electrical appliances were tested regularly to ensure their safety.

Using medicines safely

- There were audits of people's medicines but these were not thorough and only gave a stock count of people's medicines.
- A number of errors with the administration had been identified by the registered manager and appropriate action had been taken to address this with the member of staff concerned. However, these incidents had not been reported to safeguarding.
- People's medicines were stored securely.
- Where staff supported people with their medicines, we observed staff watch people take their medicines.
- The support people required with their medicines was clearly documented in people's care records.
- Medicines Administration Record (MAR) charts were completed correctly and there were no gaps where staff signed to confirm people had taken their medicines.

Preventing and controlling infection

- We observed staff handling food without wearing aprons and they were also wearing lanyards which posed a potential infection risk.
- The service was clean throughout and we saw cleaning schedules were in place.
- Most of the cleaning was completed by a contracted agency and we observed the cleaners to be present for a number of hours during our inspection.
- The on-site restaurant was clean and tidy and kitchen staff wore the correct personal protective equipment.

Systems and processes to safeguard people from the risk of abuse

● People we spoke with told us they felt safe living in the service.

● Not all staff had completed training in safeguarding.

● All of the staff we spoke with had a good understanding of how to keep people safe and what procedure they would follow to report any concerns.

● There was a safeguarding policy and procedure in place which explained what staff should do if they suspected a person was at risk of abuse.

Staffing and recruitment

● There was no dependency tool to calculate staffing levels. The county manager told us staffing levels were based on what level of support people would require if they were in the community.

● Throughout our inspection we saw staff were quick to respond to people's needs.

● Checks of staff recruitment files showed that appropriate background checks had been completed before staff commenced their employment. These checks included obtaining satisfactory references and a check with the Disclosure and Barring Service.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Assessments of people's needs were often undertaken by healthcare professionals who were referring the person to the service. This meant the registered manager did not always have a thorough overview of people's care need prior to them arriving at the service.
- One person told us they were only informed they were moving to the service when they were being discharged from hospital. Some staff we spoke with told us they felt people were admitted to the service when it wasn't suitable for their needs.
- A personal history of each person was completed and available in their care file. This included information about people's choices and preferences.

Staff support: induction, training, skills and experience

- The provider had set mandatory training for all staff to complete. Not all staff had completed this training. 10 staff had not completed their training in moving and handling. Five staff had not completed their fire safety training or training in mental health and learning disability. Not all staff had completed the emergency first aid and Mental Capacity Act training.
- Staff felt unable fully meet one person's needs as they had not received training around supporting people living with mental health needs.

The above findings constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- An induction programme was in place for new staff where they would shadow more experienced members of staff.
- Staff received regular supervision with either the registered manager or a senior member of staff. Staff we spoke with confirmed they received supervision.

Supporting people to eat and drink enough to maintain a balanced diet

- There were no care plans or risk assessments in place for people who had been identified as being nutritionally at risk. One person required a soft food diet, there was no risk assessment in place to guide staff about how they could safely support the person with maintaining a healthy nutritional intake. The member of kitchen staff we spoke with was not aware of this person's dietary requirements.
- We asked the registered manager how people's food and fluid intake was monitored and they told us care staff documented people's intake in their daily care records. We found no reference to this in one person's daily notes.

● Where people were on food and fluid charts, we found these to be incomplete with no entries being made on the charts on some occasions.
● One person had a low body weight. Their weight was not being monitored and the registered manger confirmed people were not weighed.

The above findings meant the provider is in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People we spoke with were complimentary about the food. One person we spoke with described the food as "Top notch", and a second person told us they got a choice of meals.
● We observed lunch being served in the restaurant. The food was served promptly and staff supported people where needed with their meal.
●Some people chose to have their lunch in their rooms and we saw staff taking meals to people but plates were not covered. This meant the food could be cold by the time it was served to people due to the walk from the restaurant to the service.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● There were a number of health professionals working within the service, these included occupational therapists and an assistive technology practitioner. The county manager told us a physiotherapist had also been recruited. Healthcare professionals worked with people to help them regain their independence so they could return home.
● During our inspection we saw one person's social worker was visiting them, they were also working closely with care staff to ensure they continued to meet the person's changing needs.
● A GP from the local practice visited the service daily to see people. Staff also contacted the GP outside of these visits if there were concerns about people's health.

Adapting service, design, decoration to meet people's needs
● Communal areas of the service were kept clean and there was a garden people could access via the main lounge.
● People were able to bring in personal items to make their rooms feel homelier.

Ensuring consent to care and treatment in line with law and guidance
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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● It stated in one person's care records they did not have the capacity to choose where they wanted to live. There was no MCA assessment to show how their capacity had been assessed or documentation to show

how a best interests decision had been made.

● We saw that this person was being cared for in the least restrictive way possible and staff supported the person to maintain their independence and control over choices about their care and treatment where practicable.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were positive about the care and treatment they received from staff. One person told us, "The staff treat me kindly." A second person told us how a member of staff sat with them when they felt unwell.
- Staff understood people's individual care needs.
- We observed caring and positive interaction between people and the staff.
- People's cultural and spiritual needs were taken into consideration and people were supported to practice their faith.

Supporting people to express their views and be involved in making decisions about their care

- People were involved in the planning of their care and their wishes and aspirations were documented in their care records.
- People told us they had choice about their daily lives. One person told us, "Staff come around and ask me what I want for my lunch." We saw staff supporting people to the restaurant at lunch time and they asked people where they would prefer to sit.
- People knew who they would speak to if they wanted to discuss their care.

Respecting and promoting people's privacy, dignity and independence

- Each person wore a different coloured band on their wrist to denote their risk of falls. One person we spoke with was not aware of what the band signified. The registered manager told us the colour of the band showed if people were a high, medium or low risk of falls. They added this helped staff to identify people's falls risk and staff could respond quickly if they saw someone at high risk trying to mobilise without assistance.
- The main focus of the service was to enable people to live independently so they could return home. Some people had walking aids so they could mobilise independently.
- People were treated in a way that respected their privacy and dignity. Staff knocked on people's doors before entering and personal care was given in a discreet manner

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI:□People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- Not all of people's care needs had been identified and planned for. People's weights were not monitored and there was no care plan or risk assessment in place for one person who used a hearing aid and was partially sighted.
- Staff told us they did not have the right skills or training to meet one person's needs. This was because the service was not the most appropriate for that person.
- However, staff were quick to respond to people. One person told us, "You can't fault the staff, when you ring the bell they come straight away."
- Staff had a handover at the end of each shift. Detailed information about each person was handed over to the staff coming on shift.
- People were able to maintain their interests. There was an activity coordinator who facilitated crafts, games and flower arranging. They told us they also spent time with people individually doing activities such as crosswords and reading.

Improving care quality in response to complaints or concerns

- Two satisfaction questionnaires were given to people, one by the activities coordinator and one by the provider. We saw from the responses of one questionnaire that a number of people did not know how to make a complaint. The registered manager told us they would look into this.
- The majority of the responses from the provider's survey were positive and some positive comments about the care and treatment had been given.

End of life care and support

- People's care records detailed if they did not wish to be resuscitated. There was no further information about people's end of life wishes.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

RI:Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was a lack of quality monitoring audits in place. The only audits completed were a medicines audit which was not robust and the daily record sheets were checked. There was no auditing of care plans and accidents and incidents. The registered manager confirmed the provider did not carry out any audits.
- There was no policy for quality monitoring. As a result of this, the provider had not identified any of the breaches or concerns we identified.
- People and their families were given the opportunity to provide feedback about the service but no clear action plans were in place to address any concerns raised.

The above findings constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014

- Staff working in the service were clear about their role and responsibilities.
- The registered manager was visible and spent time working alongside care staff.
- Both the county manager and registered manager worked with partnership agencies to continue to develop the service.
- The registered manager was accepting of the feedback provided throughout the inspection. However, robust systems to monitor the safety and quality of the service need to be implemented and sustained. We will review this at our next inspection.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- Statutory notifications about accidents, incidents and safeguarding matters had not been reported to the CQC as required by law.

This finding meant the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

- People and staff we spoke with told us they thought the service was well-run. Feedback we looked at on satisfaction surveys would support this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff told us they enjoyed their work and that staff morale was good. Staff also told us the registered manager was supportive with one staff member describing them as "Lovely."
● Through our observations we saw that people knew who the manager was and the manager would also speak with people's visitors. People's relatives were welcomed by staff and people who had previously lived at the service also visited.

Working in partnership with others
● Staff at the service worked with other agencies such as the local GP practice and the local authority to provide coordinated care for people. The registered manager said their relationship with hospital staff is improving and assessments of people's needs are more through which reduces the likelihood of people moving to the service when their needs could be better met elsewhere.
● The service had links with the local community such as the Church. Donations from the local garden centre had been given so people could participate in some gardening.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Commission of reportable incidents. Regulation 18 (1) (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure the nutritional and hydration needs of people were consistently met. Regulation 14 (1) (2) (a) (b) (4) (a) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement systems and processes that effectively assess, monitor and determine risks to people or maintain accurate, complete up to date records. Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive training relevant to their role.

Regulation 18(1) (2) (a)