Bennetts Castle Limited

Bennetts Castle Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Bennetts Castle Care Centre is a residential care home providing personal and nursing care to up to 64 people. The service provides support to older people living with dementia and with nursing care needs. At the time of our inspection there were 59 people using the service. The service is a purpose built care home over three floors, with care being provided on the ground and first floors.

People's experience of using this service and what we found
Risk assessments were not always in place for people's health conditions, in relation to diabetes and seizures. We found some concerns with the way medicines were managed. For example, medicine stock balances were not all correct and there was not always guidance in place about when to administer 'as required' (PRN) medicines. Quality assurance and monitoring systems were not always effective.

Systems were in place to help protect people from the risk of abuse. There were enough staff working at the service and the provider had robust staff recruitment practices in place. Accidents and incidents were reviewed and analysed to help reduce the risk of further such occurrences. Steps had been taken to ensure the premises were safe. Infection prevention and control measures were in place.

People and staff told us there was an open and positive culture at the service. People were supported to express their views. The provider was aware of their legal obligations, and worked with other agencies to develop best practice and share knowledge.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 13 September 2018).

Why we inspected
We undertook this inspection as part of a random selection of services rated Good and Outstanding.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Bennetts Castle Care Centre on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to assessing risks related to diabetes and seizure, the management of medicines and the quality assurance and monitoring systems used by the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Bennetts Castle Care Centre

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by an inspector, a Specialist Advisor with a specialism in nursing care 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.

Service and service type
Bennetts Castle Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Bennetts Castle Care Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post. However, there was a manager in post who was in the process of applying for registration with the Care Quality Commission.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service and four relatives. We spoke with 11 members of staff, including the manager, two directors, the deputy manager, three care assistants, two senior care assistants and two nurses. We observed how staff interacted with people. We looked at a number of care and medicines records for people and staff recruitment files. We examined records related to the running of the service, including policies and procures.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant 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.

Assessing risk, safety monitoring and management

● Risk assessments were in place for people. These covered a variety of risks including those related to continence, mobility, falls and skin integrity. These included information about how to mitigate risks and were reviewed on a monthly basis.

● However, we found some instances of people's health conditions not being properly risk assessed. We were told by staff that six people on the first floor had diabetes, but risk assessments were only in place for three of them. Further, one person on the first floor was assessed as at risk of having seizures, but there was no risk assessment in place around this. This meant there was a lack of clear guidance to staff about how to support people with the risks associated with these health conditions.

● Staff had undertaken training in the management of diabetes and epilepsy. Staff we spoke with were aware of which people had these heath conditions.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people, which potentially put people at risk. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the lack of risk assessments with the manager. After the inspection they sent us confirmation that all required risk assessments had been put in place.

● Checks were carried out to help ensure the premises and equipment used were safe. These included gas, electrical and fire safety checks.

Using medicines safely

● Although we found some instances of good practice, we found that medicines were not always managed safely.

● We found three instances where the stock balances did not reflect the amounts recorded as being in stock, so that there were more tablets than there should have been. This suggested these medicines had been signed as given when in fact they had not. Other stock balances we checked were correct.

● Where people were prescribed medicines on an 'as required' (PRN) basis there were generally protocols in place to provide guidance to staff on when to administer them. However, we found that one person had been prescribed three medicines on a PRN basis and there were no protocols in place for any of them. We discussed this with the nurse in charge who wrote up protocols during the course of our inspection.

● Some people were prescribed creams to be applied to their bodies. Staff who administered these told us they knew where to apply the creams as they had been told verbally, and there was information about this

in people's care plans. However, we did not see body maps in place to indicate where the creams were supposed to be applied, which meant there was a risk of them being applied incorrectly.

The provider had failed to ensure that there were effective systems in place for the safe administration of medicines, which potentially put people at risk. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Systems and processes were in place to help protect people from the risk of abuse. There was a safeguarding policy which made clear the provider had a responsibility to report any allegations of abuse to the local authority and Care Quality Commission.
● Comprehensive records were maintained of any allegations of abuse and subsequent action taken. These showed allegations had been dealt with in line with the policy.
● Staff had undertaken training about safeguarding adults and understood their responsibility to report any allegations of abuse. One member of staff told us, "I would report it to my nurse."
● People and relatives told us they felt safe using the service. One relative said, "Yes we feel (person) is safe here as long as their one-to-one continues. The carers have been outstanding in looking after (person), so yes they're safe here. The carers have learnt how to work with (person), we find all the staff here helpful." A person told us, "When I first arrived here, I couldn't even walk much but I'm getting there now slowly, and I can walk with a stick or use my walker. Like I said, a few weeks ago I couldn't even do that. They (staff) keep a good eye on me here and all the staff are nice pleasant people."

Staffing and recruitment

● There were enough staff working at the service to keep people safe. Staff told us they had enough time to carry out their duties. We observed staff were able to respond to people promptly when assistance was needed.
● People and relatives told us there were enough staff. One relative said, "Normally I think there's plenty of staff around."
● The provider had robust staff recruitment practices in place to help ensure suitable staff were employed. Various pre-employment checks were carried out on prospective staff, including obtaining proof of identity, employment refences and carrying out a criminal records check.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● At the time of our inspection there were no restrictions in place on visitors to the service. Visitors were able to come as they liked and visit people in their own rooms. This was in line with current government guidance at the time.

Learning lessons when things go wrong

● Steps were taken to learn lessons when things went wrong. The provider had an accident and incident policy in place to guide staff and accidents and incidents were recorded, along with details of follow up action. Accidents and incidents were analysed for trends and patterns to see what actions could be taken to reduce the risk of further similar occurrence.

● A relative told us, "(Person's) had a couple of falls since they've been in but now they're checking them often and they ring us to let us know what's going on and how (person) is doing which is reassuring."

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

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.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care

- The provider had various quality assurance and monitoring systems in place. For example, audits were carried out of health and safety and infection control practices within the service. However, quality assurance systems were not always effective.
- For example, risk assessments were subject to monthly reviews, but these reviews had failed to identify that risk assessments were not always in place for people's health conditions, in particular, diabetes and the risk of seizures. Further, medicines audits were carried out, but these had not identified issues we found with medicines, such as the lack of body maps to guide staff with the administration of prescribed creams.

The provider had failed to implement effective quality assurance and monitoring systems, which potentially put people at risk. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider had a positive culture that was open and person centred. There was a manager in place who told us they had an 'open door' policy in terms of staff and people having access to them. The manager was in the process of applying to become registered with the Care Quality Commission at the time of our inspection.
- Staff spoke positively about the manager and the working culture at the service. One staff member said of the manager, "They are nice, they are an open person. They give opportunities of leaning to staff." Another member of staff described the manager as 'Excellent' and went on to say, "It's nice having someone I can go to if need be. They are very approachable."
- People and relatives told us the provider was helpful. One relative said, "If we have had the odd problems they've always been sorted swiftly but you can't expect everything so it's only the odd hiccup, like things went missing from (person's) room, only the once though."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Where things went wrong, the provider had been open and honest with people about this. Systems were in place to address when things went wrong, such as the complaints procedure and the way accidents and incidents were responded to. Any suspected safeguarding incidents were referred to the local authority.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The manager and staff were clear about their roles. Staff understood their individual role and who they were accountable to. They were provided with a copy of their job description to help provide clarity of what was expected of them.

● The Manager understood their legal responsibilities, for example about when to notify the Care Quality Commission of significant events, and records shown this was done when required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider engaged with people, relatives and staff to seek their views and involve them in the service. The provider was in the process of carrying out a survey of people and relatives at the time of inspection, although they had not received any responses. The previous survey was carried out in April 2021 and feedback was positive from this.

● Records were kept of compliments the provider received. For example, one relative had written, "The staff are very good, kind and helpful." Another relative wrote, "The care you gave was first class, always with a smile."

● The provider considered equality characteristics. For example, staff recruitment was carried out in line with good practice in relation to equality and diversity.

● The provider worked with other agencies to develop best practice and share knowledge, and ensure people got the right care. For example, the provider worked with a variety of health care providers to meet people's needs. The manager attended a provider's forum run by the local authority which provided guidance about relevant topics.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to effectively asses the risks to the health and safety of service users receiving care or treatment and had failed to implement effective systems for the proper and safe management of medicines. 12 (1) (2) (a) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to implement effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. 17 (1) (2) (a)