Benridge Care Homes Limited

Benridge Residential Care Home

Inspection report

53 Queens Road
Southport
Merseyside
PR9 9HB

Tel: 01704530378
Website: www.emiresidential.co.uk

Date of inspection visit:
07 April 2021
09 April 2021
14 April 2021
21 April 2021

Date of publication:
06 July 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Benridge Residential Care Home is a residential care service that provides accommodation and personal care for up to 27 people, including those living with dementia. At the time of our inspection, there were 23 people living at the service.

People's experience of using this service and what we found
Not all risks were safely assessed and mitigated to maintain people's safety. The registered manager failed to ensure the environment was sufficiently clean and well maintained. There were missed opportunities to effectively analyse accidents and incidents.

There were systems in place to assess people's level of need and staffing requirements. However, we observed there were not enough staff and that people did not always receive the support they needed in a timely way. We have made a recommendation that contingency plans for critical staff shortages are reviewed.

Systems and processes to monitor and improve the quality and safety of the service were not always effective. Some of the concerns found during the inspection had been identified by the providers monitoring systems. However, where issues had been identified, actions were not put in place to address these in a timely manner.

People received their medicines as prescribed. People received care that was person centred and based on their individual needs and preferences. Relatives told us staff knew people well and how to communicate with them in a way they understood

Staff spoke positively about using technology to produce an individual activity programme which was tailored to people's likes and dislikes. The provider ensured safe visiting procedures were in place to allow relatives to visit their loved ones at the end of their life, as per the governments COVID-19 guidance.

The provider recognised the value of regular communication with people using the service, relatives and staff. The registered manager acted in accordance with their duty and shared information in an open, honest and timely manner.

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

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about staffing and infection control. A decision was made for us to inspect and examine those risks.

We inspected and found there were concerns in relation to the environment, infection control and staffing levels, so we widened the scope of the inspection to become a focused inspection which included the key questions of Safe, Responsive and Well-Led.

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.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection.

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

We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the safe care and treatment of people and governance 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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 responsive?

Good

The service was 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

Benridge Residential Care Home

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 Care Act 2014.

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 two inspectors.

Service and service type
Benridge Residential Care Home 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.

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
This inspection was unannounced.

Inspection activity started on 7 April 2021 and ended on 27 April 2021. We visited the home on 7 April 2021 and 9 April 2021. We completed virtual site visits on 15 April 2021 and 21 April 2021 to review the providers

governance systems.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection.

During the inspection
Due to widening the scope of the inspection to become a focused inspection, we sought feedback from the local authority and fire service ahead of the second site visit on 9 April 2021.

We spoke with seven relatives about their experience of the care provided. We spoke with eleven members of staff including the provider, registered manager, deputy manager, senior care worker, care workers and the maintenance person. We 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 a range of records. This included six people's care records and multiple medication records. We looked at four staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to review evidence and seek clarification from the provider to validate evidence found. This included training information and quality assurance records. We spoke with one professional who regularly visited the service.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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; Learning lessons when things go wrong

● Not all risks were safely assessed and mitigated to maintain people's safety. One person's pre-admission information showed they had risks associated with an ongoing health condition. The registered manager had not assessed these risks on admission or during their initial stay.

●Safety concerns within the environment had not always been addressed in a timely way to ensure people were safe. We found a cracked window in one person's bedroom and a hole in the laundry room ceiling which posed a fire safety risk. The provider told us the COVID-19 pandemic had made repairs in the environment difficult. However no plans were in place to manage the risk they posed to people.

●One person's falls risk assessment did not reflect all recent falls. This meant that the risk to this person's safety had not been accurately assessed.

●Incidents were recorded and reviewed. However, the analysis of incidents was not always effective and there were missed opportunities to identify patterns and trends. We found that incidents often reoccurred.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate risk was effectively managed. This placed people at risk of harm. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People and relatives told us they felt care was delivered safely by staff who knew them. Comments included, "[staff] are very keen on making sure everybody is safe," and "[person] is safe and well cared for."

Preventing and controlling infection

●The registered manager failed to ensure the environment was sufficiently clean and well maintained.

●We found several issues with one bathroom including strong odours, storage of cleaning equipment, and unclean taps and toilet. Staff described the bathroom as "disgusting," but told us they had to use the room as it housed the only working bath in the home.

●Cleaning records had not been completed for several days and did not demonstrate that areas such as toilets and bathrooms had been sufficiently cleaned.

●The home did not always ensure best practice guidance in relation COVID-19 was followed. For example, we observed one person who was in 'self-isolation' moving freely in communal corridors. This made good infection control practice difficult.

We found no evidence that people had been harmed. However, inappropriate management of infection control puts people at risk of infection. This was a breach of Regulation 12 (Safe Care and Treatment) of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised our concerns with the local authority infection prevention and control team.

●We noticed an improvement in the cleanliness of the home and found more domestic staff on duty when we returned for the second day.
●Staff had received training in the use of personal protective equipment (PPE). Our observations found staff were using PPE effectively.

The provider responded immediately after the inspection. They provided evidence of immediate improvements to the cleanliness and maintenance of the environment.

Staffing and recruitment
●There were systems in place to assess people's level of need and staffing requirements. However, we observed there were not enough staff and that people did not always receive the support they needed in a timely way.
●Staff told us they did not feel there were enough staff to meet people's needs and described the staffing shortages as "stressful." Some staff felt anxious that they were unable to the provide the quality of care they wanted.
● The provider had contingency plans in place for safe staffing levels but these were not always effective.

We recommend the provider reviews their contingency plan for critical staff shortages.

●Staff were safely recruited. Staff files contained the necessary checks and documents to ensure fit and proper people were employed.

The provider confirmed that they had recruited four new members of staff, who were undergoing recruitment checks..

Systems and processes to safeguard people from the risk of abuse
● The provider had effective safeguarding systems in place.
● Staff had received training to recognise abuse and knew what action to take to keep people safe. One staff member commented, "I would report any concerns to the manager. You do what is right for the residents."
●Relatives spoke positively about the registered manager's response to incidents. One relative told us, "The [registered manager] always reports every little incident, even things I would think nothing of."

Using medicines safely
● People received their medicines as prescribed. Medicines administration records (MAR) were used to record all medicines administered and daily stock counts were completed.
● Senior staff completed medication training as part of their induction.
● When senior staff found errors during checks, these were investigated.

Good

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Outstanding. At this inspection this key question has now deteriorated to Good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People received care that was person centred and based on their individual needs and preferences.

●Information about people's life histories and what was important to them was recorded in detail. This information provided staff with the ability to get to know people before supporting them.

● People and relatives were involved in developing their care and support plans; people were empowered to make choices about how they wished for this to be delivered.

● Relatives told us staff knew people's needs, personalities and behaviours well and provided support in line with this. One family member told us, " I write letters telling [person] how much I love her. One of the carers laminated all the letters and put them into a photo album so when [person] gets upset, the carer takes [person] to their room and they look at the album."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

●People's communication needs were identified, and information was available in different formats for people to use.

● Pictures of the menu appeared outside the dining room on a TV screen. This helped people understand what was on offer before they made a choice.

●Relatives told us staff knew people well and how to communicate with them in a way they understood. One relative told us, "When [person] is with [staff] she interacts well and [staff] understands how she communicates."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Staff spoke positively about using technology to produce an individual activity programme which was tailored to people's likes and dislikes. This meant people engaged in activities which they found meaningful.

●Staff regularly evaluated people's participation in activities to ensure they were meeting their social needs.

●The home was following the governments COVID-19 guidance to enable people to have relatives visit them and individual COVID-19 visitation plans had been developed. Relatives told us how visiting had improved their loved one's wellbeing.

●People were supported to telephone or use video calls with their relatives when they were unable to visit in

person. One relative told us, "The home sent video links so I could see [person] over Christmas which was lovely."

●The home organised regular celebrations for example birthdays, Valentine's day and Chinese New Year, with photographs being shared with relatives through social media and newsletters.

●Relatives spoke positively about the activities programme. One relative told us, "there is always all sorts going on such as bingo, painting and dancing."

Improving care quality in response to complaints or concerns

●The home had a complaints policy which was made available to people and their relatives.

● At the time of the inspection, the home had not received any complaints.

●People and relatives knew how to make complaints should they need to. They told us they believed they would be listened to by the registered manager. Comments included, "[registered manager] is easy to approach," and "I would find it easy to talk to [registered manager], she's human."

End of life care and support

●The service was not supporting anyone with end of life care. However, the registered manager was aware of their responsibilities regarding this.

●The home had a policy which referenced best practice guidance in relation to end of life care.

●The provider ensured safe visiting procedures were in place to allow relatives to visit their loved ones at the end of their life, as per the governments COVID-19 guidance.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated 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.

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

- Systems in place to monitor the quality and safety of the service were not always effective. For example, safety and quality audits were not regularly completed. This meant opportunities to improve safety and quality were missed. In addition, records relating to essential safety checks were not kept up to date. This made it difficult for the registered manager to monitor compliance.
- Some of the concerns found during the inspection had been identified by the providers monitoring systems. However, where issues had been identified, actions were not always put in place to address these in a timely manner.
- Risks to people were not always assessed effectively. One person had had a recent fall, but no risk assessment had been completed, and one person's risk assessment was inaccurate. This meant control measures were not put in place in a timely manner to reduce the risk going forward.
- We found the provider had not sent some required notifications to the CQC. Statutory notifications are certain changes, events and incidents that the registered providers must notify us about that affect their service or the people who use it. This meant the CQC could not undertake its regulatory function effectively.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate safety was effectively managed. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection and submitted the missing statutory notifications. They told us they were implementing a bespoke online system to improve the safety and quality of the service.

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

- The provider understood the value of a person centred approach which was reflected in the way staff provided care.
- Staff told us they were well supported in their roles and could raise any concerns they had with senior staff.
- Relatives were positive about their loved one's health and wellbeing outcomes. One relative described how the registered manager took their loved one to hospital appointments when there was an issue with hospital transport. The relative explained their loved one is walking again and felt the home contributed to

this.

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

● The provider recognised the value of regular communication with people using the service, relatives and staff.

●The COVID-19 pandemic meant that the home had to adapt its approach when meeting with people and relatives. Smaller residents meetings were held to allow for social distancing and meetings with relatives were moved online.

● Staff received regular surveys which the registered manager reviewed to identify areas of improvement.

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; Working in partnership with others

●The registered manager acted in accordance with their duty and shared information with people and relatives in an open, honest and timely manner.

● Relatives told us the registered manager communicated well and updated them when there were changes to their loved one's health. One relative told us, "[registered manager] is very open, when anything happens, they are on the phone to notify us."

● A professional who regularly visit the home provided positive feedback about the management and staff with regards to successfully managing people's health conditions.

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 12 HSCA RA Regulations 2014 Safe care and treatment Not all risks were safely assessed and mitigated to maintain people's safety. Inappropriate management of infection control put people at risk of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor the quality and safety of the service were not always effective.