Benoni Nursing Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

Benoni is a nursing home which offers care and support for up to 25 predominantly older people. At the time of the inspection there were 19 people living at the service. Some of these people were living with dementia. Bedrooms were arranged over three floors with a passenger lift and stair lift providing access for people to the upper floors.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

This unannounced focused inspection took place on 11 July 2017. The last comprehensive inspection took place on 28 April and 3 May 2017. We identified four breaches of the regulations at that inspection. The breaches related to staffing levels, the management of risk, lack of effective quality assurance processes and the poor condition of the premises. A warning notice was issued regarding the management of medicines, fire risk management, the provision of hot water and infection control issues. Statutory requirements were issued for the other breaches of the regulations. The provider sent the Care Quality Commission an action plan detailing how the service would meet the requirements of the regulations. We carried out this focused inspection to check on the action taken by the service to meet the requirements of the warning notice. The action taken to address the requirements will be reviewed at a comprehensive inspection at a later date.

This report only covers our finding in relation to "Is the service Safe". You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Benoni Nursing Home on our website at www.cqc.org.uk.

During this inspection we checked the services medicines systems. The management of prescribed medicines at Benoni had improved. Handwritten entries on the medicine management record were always signed by two staff to help ensure the risk of errors was reduced. Where people were prescribed pain relieving patches records were being kept consistently of where the patch was sited to help ensure it was always a different position on the person's body.

However, we still found some errors. Staff were required to count medicines at each medicine round to ensure all were accounted for. The records for one medicine did not tally with the stock held. One person was on a prescribed medicine, which was monitored by a regular blood test. The result of this blood test led to frequent changes in the dose of the medicine. The records relating to this medicine did not show the person had received the correct dose of this medicine, according to advice from the GP. Prescribed creams continued to not be dated when opened. Regular medicine audits were now being carried out and showed some improvement in errors. However, the audits were not being entirely effective in identifying issues found at this inspection.

Although action had been taken to address the concerns in the warning notice about the safe management of medicines further improvements are required and the service remained in breach of the requirements of the regulations.

The service had now followed their own recommendation from the last infection control audit in 2016 which stated 'liquid soap must not be topped up' and that sealed cartridges of liquid soap should be used. We found new sealed cartridge soap dispensers were in place.

The maintenance person had been replaced at the service since the last inspection. Work had been carried out to ensure that hot water was available in all outlets at a safe temperature. Further work was planned to provide constant hot water to a staff toilet where it was found to be cold on the day of this inspection.

A large fan, without a guard, that was found in regular use at the top of the stairs at the last inspection had now been removed.

A Fire and Rescue Service report carried out in July 2016 had requested action to be taken to ensure the service was safe. This had not been done at the last inspection. A further inspection was requested in June 2017 which required the service to take specific actions. At this inspection we found an external fire service professional had been commissioned to carry out all the required improvements to Benoni to ensure it met the necessary fire service requirements. The service had carried out a fire risk assessment and regular drills and fire training were now in place for all staff.

The service will have the outstanding requirements reviewed at the next comprehensive inspection. At this inspection we found a continued breach of Regulation 17 of the Health and Social care act 2008 (Regulated activities) 2014.

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 entirely safe. Systems for the management of medicines were not always robust. Audit of medicines management were not entirely effective.

Regular maintenance check were monitoring the temperature of the hot water throughout the service regularly. This was within safe limits.

A comprehensive fire risk assessment had been carried out and the service had completed the necessary work to comply with fire regulations.

Infection control concerns had been addressed with new liquid soap cartridges.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 11 July 2017 and was unannounced. The inspection was carried out by one adult social care inspector.

The service was previously inspected on 28 April and 3 May 2017 when significant breaches of regulations were identified. A warning notice was issued for one breach of the regulations.

Before the inspection the provider sent the Care Quality Commission information relating to how they had addressed the concerns found at the last inspection. We reviewed this and other information we held about the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with two people living at the service. Not everyone we met who was living at Benoni was able to give us their verbal views of the care and support they received due to their health needs. We looked around the premises and observed care practices. We spoke with three staff.

We looked at medicines records for 19 people and other records relating to the management of risks at the service such as maintenance checks and fire risk assessment.

Requires Improvement

Is the service safe?

Our findings

The provider and the registered manager had provided the Care Quality Commission with comprehensive information detailing how they had addressed the concerns found in the warning notice issued following our last inspection. Staff told us that many changes had taken place to improve the service provided to people living at Benoni.

At the last inspection we were concerned that medicine administration records (MAR) were not always an accurate record of when people had been given their prescribed medicines. Some people did not always receive their medicines as prescribed. Prescribed creams were not dated upon opening. Handwritten entries on to the MAR by staff following guidance from healthcare professionals, were not always signed by two staff to help reduce the risk of errors. Changes to people's prescribed medicines were not always clearly recorded and records of who authorised the change were not present. Pain relieving patches were not being consistently recorded where they were placed on the body. This meant concurrent patches could be placed on the same site which is not medically recommended. Medicine audits were not being conducted in line with the policy held at the service. Some medicines were found to be missing from the number recorded at an audit last carried out in April 2016. no action had been taken to address this concern.

At this inspection we checked the MAR and found that it was not always possible to confirm if people always received their medicines as prescribed. One person was prescribed a medicine, which was monitored by a regular blood test. The result of this blood test led to frequent changes in the dose of the medicine. The GP had faxed written information to the service detailing specifically what dose was to be given to the person on each day of the week. The MAR relating to this medicine did not show the person had received the correct dose of this medicine on every day, according to advice from the GP. We discussed this with the registered manager who assured us this had been given correctly but that staff had not recorded this appropriately.

Since the last inspection staff were required to count all medicines at each medicine round to ensure all were accounted for. Monthly audits of tablets held at the service were identifying some discrepancies in stock held against the records kept, although the number of errors had improved over recent months. The records for one person's medicine did not tally with the stock held. The count of one medicine went up from 14 to 26 over the weekend prior to this inspection. A delivery of 100 tablets was seen as having arrived during the week before, but the registered manager could not account for the tally going up by just 12 tablets over the weekend.

Prescribed creams continued to not be dated when opened as found at the last inspection. This meant staff were not aware when the item should be disposed of. We found unnamed cream in a bathroom being used communally. Several tubs of prescribed creams found in people's bedrooms, had been in use so long the prescription label was unreadable. We reported these issues to the registered manager and these creams were removed at the time of this inspection.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

2014.

We saw staff had transcribed medicines for people, on to the MAR following advice from medical staff. These handwritten entries were signed and had been witnessed by a second member of staff. This meant that the risk of potential errors was reduced and helped ensure people always received their medicines safely.

The service were storing medicines that required cold storage, there was a medicine refrigerator at the service. There were records that showed medicine refrigerator temperatures were monitored. An audit trail was kept of medicines received into the service and those returned to the pharmacy for destruction.

Some people were prescribed pain relieving patches. At this inspection we saw staff had recorded where each patch was placed and this was rotated each time. We judged that some improvements had been made and that medicines administration was safer. However, we found the service remained in breach of the regulations regarding record keeping.

The warning notice stated that very hot water was found in one person's bedroom, and no hot water was provided in another bedroom. The maintenance person had been replaced at the service since the last inspection. This issue had now been addressed. Although further work was required to complete work on the water supply and provide hot water to the staff toilet on the first floor, which was found to be cold on the day of this inspection. Regular maintenance checks were being carried out to monitor the temperature of the hot water at the service.

A large unprotected electric fan, used regularly, was found on the staircase at the service at the last inspection. This posed a risk to people using the stairs. This had been removed by the provider.

A Fire and Rescue Service report carried out in July 2016 had requested action to be taken to ensure the service was safe. This had not been done at the last inspection. An additional fire service inspection had taken place in June 2017 following our last inspection. This set required actions to bring the service up to the standards required by the fire regulations. All the necessary work identified by the fire service had been completed. All bedroom fire door closures had been checked as working appropriately. All fire doors had been serviced to ensure they operated safely. 10 staff were booked on to fire warden training in September 2017 to increase the number of wardens from the current two on the staff at the time of this inspection. In addition, all the other staff having undertaken fire safety training. There had been fire drills carried out. A comprehensive fire risk assessment had been completed and the provider told us they were planning to provide walkie talkies and a pre programmed mobile phone to be held together with the personal emergency evacuation plans at the fire point in the service. People who were unable to walk unaided had been provided with their own evacuation sledge to enable them to be evacuated from the building in an emergency. The service had met the requirements for fire safety in the warning notice.

At the last inspection we found the service had not followed their own recommendation from their last infection control audit in 2016 which stated 'liquid soap must not be topped up' and sealed cartridges of liquid soap should be used. At this inspection we found new sealed cartridge soap dispensers were in place and had replaced old soap dispenser which were being repeatedly topped up. We looked around the building and found the environment was clean and there were no unpleasant odours. Hand gel dispensers were available throughout the building. Personal protective equipment (PPE) such as aprons and gloves were available for staff and used appropriately to reduce cross infection risks. This meant the requirements of the warning notice had been met.

The service held the personal money for people who lived at the service. People were able to easily access this money to use for hairdressing, toiletries and items they may wish to purchase. The money managed by the registered manager, regularly audited and no errors had been identified.

Accidents and incidents that took place in the service were recorded by staff in people's records. Such events were audited by the registered manager. This meant that any patterns or trends would be recognised, addressed and the risk of re-occurrence was reduced.

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 17 HSCA RA Regulations 2014 Good governance The service did not have robust systems or processes established and operated to assess and monitor the service provided. Medicines records were not accurate and regular audits had not identified this concern.