Care Quality Commission

Mrs Gail Smith and Russell Smith

Benamy Care

Inspection report

25 Candlish Terrace,
Seaham,
County Durham,
SR7 7LG
Tel: 0191 581 3039
Website: N/A

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

We inspected the service on 24 July 2014 and it was unannounced.

Benamy Care is an end of terrace house in Seaham. The home provides care and accommodation to five people with learning disabilities.

At the time of our inspection there was a registered manager in post. 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.

We found the provider carried out annual appraisals for staff but could find no evidence of supervisions being carried.

Staff working in the home were provided with training but this was not refreshed regularly and there was no evidence of training being updated as regulations and best practice changed.

Summary of findings

Staffing levels in the home meant that activities were restricted to group activities rather than individual activities. Staff worked long staff worked long days, for example 8am to 8pm and had no support whilst on duty except via telephone. This breached Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The provider failed to follow advice given by health professionals and there was evidence of active disregard to recommendations health professionals had made. This breached Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The provider failed to ensure people's medicines were properly stored and administered and was unable to provide evidence of staff having received appropriate training in the handling of medicines. This breached Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The provider failed to carry out infection control audits and failed to store items like toothbrushes and first aid equipment in a way which would prevent the risk of exposure and spread of infection. This breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The provider failed to obtain proper consent to carry out care on the people who used the service. This breached Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The provider failed to ensure that the home was safe because appropriate maintenance and testing was not carried out in the home. This breached Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider failed to assess and monitor the quality of the service provided. This breached Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Summary of findings

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 was not safe.

Risk assessments were carried out but did not cover all areas and were not cross referenced with care plans.

The provider did not take appropriate action to prevent the risk of infections.

Staff did not receive regularly updated training in safeguarding, Mental Capacity Act 2005 or Deprivation of Liberties Safeguards.

Inadequate

Is the service effective?
The service was not always effective.

Care plans indicated that people were included in the planning of their care but were not available in alternative formats.

People's care plans had only limited information included in them.

Requires Improvement

Is the service caring?
The service was not always caring.

People were treated with respect and were spoken to courteously.

Staff spoke with people in a polite and courteous manner.

The provider had policies in place to ensure staff knew how to treat people with dignity and respect and were aware of their human rights. These policies were not regularly reviewed and there was no evidence that staff employed to work in the home were aware of the policies.

Some practices had no regard to individual privacy or dignity.

Requires Improvement

Is the service responsive?
The service was not always responsive.

The provider did not routinely seek advice and support from professionals regarding people who used the service or their particular needs.

There was evidence that recommendations from medical professionals were not always followed.

The provider arranged for people who used the service to take part in various activities and outings however these were group activities rather than for individuals.

Requires Improvement

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

The provider had a complaints procedure in place but this was not displayed in the home.

The provider's service user guide was cut and pasted from a local authority document and was not written or changed for the service or the people who used it.

No audits were carried out by the provider to ensure the quality of the service provided.

Benamy Care

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, 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 24 July 2014 and was unannounced.

The inspection team consisted of two Adult Social Care inspectors and a specialist advisor whose expertise is in learning disabilities.

Before the inspection, we asked the provider to complete 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. The fully completed PIR was received after the inspection.

We looked at the information we had about the provider including statutory notifications that were submitted and information from the local authority.

During our inspection we spoke with two people who used the service and one of the providers. We looked at the care plans of three people who used the service, observed how staff interacted with people and looked at staff duty rosters, and a recruitment file as well as records relating to the home and the quality of the service provided.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

We looked at the records for one person who was employed at the home. We were told by one of the providers that there were two people who were employed at the home in addition to the two providers who also worked there. When we looked at the staff record we could find no evidence of pre-employment recruitment checks. We did not see application forms or references for the employee and therefore were unable to be certain that people who were employed by the service were suitable.

We were told by one of the providers of the home that prior to starting work a Criminal Records Bureau (CRB) or Disclosure and Barring Service (DBS) check was carried out. These checks help employers make safer recruitment decisions helping to prevent unsuitable people from working with vulnerable groups. The provider was unable to show us evidence of these checks being carried out.

We spoke with one of the providers who told us the staff employed at the home had worked there for a number of years. She could not recall if an application form had been completed and was not aware of whether there was any further paperwork relating to the recruitment of staff.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005 (MCA). They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We saw care plans contained mental capacity assessments however these appeared the same for each person who used the service. Each assessment had an identical statement that the individual could not make decisions about anything without support.

We saw staff had received training in both the MCA and DoLS in June 2012 but no refresher training had been provided meaning staff may not be aware of changes in legislation. The provider we spoke with was aware of people's right to make choices regarding their care however we did see evidence that the provider made decisions relating to people's everyday lives but told us they did not believe this was a deprivation of their liberties. For example some of the people who lived in the home were not allowed to stay home alone and some were not allowed outside the home alone. Another person had their razor taken from them, when asked the reason for this the provider told us it was because he would cut himself if allowed to shave independently. There was no evidence of best interest decisions with family, friends or representatives meaning the assessments had not been held in accordance with the MCA.

This breached Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider had failed to obtain proper consent to carry out care.

We asked the provider how they dealt with behaviour that challenges the service. We were told that none of the people living in the home exhibited this type of behaviour however throughout the day we witnessed one of the people who used the service displaying behaviour that was dominating toward others and required behavioural management. We spoke with the provider about what we had witnessed but they told us they had not seen anything of concern.

We looked at the risk assessments that had been carried out for three people who lived in the home. We found that although some risks had been identified they were not cross referenced with care plans and did not give clear guidance on actions to take to reduce risks. There were no risk assessments relating to managing behaviour for any of the three people whose care plans we looked at.

We asked the provider to show us a copy of the staff roster for the home. The roster we were given was dated May 2013 however, we were told this roster was still in operation. The roster showed there was only one member of staff on duty at any time. The roster showed staff worked long days, for example 8am to 8pm. During this time staff had no opportunity for a break and there was no support for staff except via telephone. The roster showed the majority of hours were worked by the two people who owned the service with additional cover provided by other staff. The provider felt this level of cover and support was sufficient and did not cause a problem.

We looked at the systems that were in place for the receipt, storage and administration of medicines. We saw the provider had a lockable medicines trolley which was stored in the kitchen of the home. When we looked at the trolley

Inadequate

Is the service safe?

we found it was not locked and although some medicines were stored in it there were also other items stored including hair combs, matches, money and cleaning equipment.

We saw a monitored dosage system was used for the majority of medicines used in the home with short term medicines, creams and inhalers supplied in boxes or bottles. There was no evidence that medicines were checked when they were received and there was no evidence of unused medicines being returned to the pharmacy.

We looked at the medication administration record (MAR) for four of the people who used the service. We found one person was prescribed a medicine with directions to 'take one every day', 'take 30 to 60 minutes before food.' The MAR showed the medicine was given at 9AM and the provider told us breakfast time finished at 10AM. This combined with people's daily activities meant there may not have been adequate time between taking medicine and eating. We also saw one person's MAR had an 'M' in some entries. A note on the MAR said 'M=mams' but it was not clear if the prescribed medication was given by the mother of the service user or if it was given at all.

We looked at the staff training records in relation to the safe handling and administration of medicines. We were told by the owner that everyone was trained to administer medicines but the training records provided only contained evidence of two people completing the required training. One of these people was not shown on the staff rota so we could not be sure if this person was working when medicines were administered. We asked the provider to provide us with evidence of training but were told the certificates had been mislaid. This meant people were at risk of receiving the wrong medicines.

This breached Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider had failed to make suitable arrangements for the safe administration of medicines.

We looked at staff training records and found training had been provided in the protection of vulnerable adults during 2012. There had been no updates or refreshers in relation to this training which meant that staff did not have up-to-date knowledge.

We asked the provider for the most recent infection control audit carried out in the home but were told these audits were not carried out. We looked around the home in order to establish whether people were at risk of infection. We found the bathroom downstairs had blinds at the window which were dusty and rusted, and the shower cubicle in the room was also dirty. On a shelf by the sink we found toothbrushes belonging to the people who used the service. All toothbrushes were stored together in a cup allowing the heads to touch. In addition the cup the brushes were stored in was mouldy and the heads of the toothbrushes were worn and discoloured.

We looked at the first aid kit that was kept in the home. We found anaesthetic creams were passed their use by dates and also found dried and bloodied bandages were kept in the first aid kit. All these things meant people who used the service were not being protected from the risks of infection because the provider was not taking appropriate action to prevent the spread of cross infection.

This breached Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider had failed to take appropriate steps to prevent the spread of infection.

Requires Improvement

Is the service effective?

Our findings

We spoke with people who lived in the home however due to their individual medical conditions none of them were able to confirm whether they were involved in the planning of their care.

We looked at the care plans for all of the people living at the home and found they were completed in the same way for each person and were not person centred. Care plans did indicate that people were included in the planning of their care but did not take into account people's ability to read and understand the content of the plans. There were no alternative formats available to help people understand for example pictures or symbols and therefore people using the service could not be certain of what had been written in their care plans.

During our inspection we observed how staff interacted with people who used the service. We saw that staff spoke with people in a polite and courteous manner and that all the people living at the home understood verbal communications that were used throughout the day. There was a member of staff available if people needed assistance however as there was only one member of staff on duty for the majority of the time this meant people may have to wait for assistance however, we did not observe this to be the case during our inspection

People's care plans had only limited information included in them. For example two people had complex health needs and another had received significant treatment for a health condition however there was no information available about the treatment or any effects it might have in relation to everyday health matters. No documentation was available regarding follow up plans or the need for further monitoring. We asked the provider for the documentation relating to this but were told they did not know where it was located.

We saw the provider carried out annual appraisals with staff. We found documentation which showed discussions had been held and the employee had been given the opportunity to make comments. We did not see any evidence of staff supervisions being carried out throughout the year. We were unable to confirm with staff at the time of the inspection

We saw training had been provided in areas like safeguarding, moving and handling and infection control enabling people to carry out their roles however most of this training had lapsed which meant staff were not up to date with guidance and best practice recommendations. Observations throughout our inspection led us to question if training which had been provided was effective. We did not see any evidence that the staff had received training which was related to the medical conditions of the people they cared for.

The provider had made arrangements for a local dentist to make visits to the home and we saw evidence that people who used the service had access to opticians, podiatrists and local GPs. although the provider had no evidence to show they discussed people's health concerns with them or that people understood what treatment options were available to them.

We saw people who used the service were consulted about what food they would like to eat and a weekly menu was planned for this purpose. Our observations showed although people had choice the meals selected were not changed in any way to make them more nutritionally balance and healthy. During our inspection we saw people who used the service were encouraged to assist with meal preparation which included setting the table and preparing food.

We saw people who used the service had a daily diary which was completed by a member of staff and gave details of activities they had participated in, the foods they ate and their general health throughout the day. One of the people who used the service attended regular supported employment as well as attending group outings to the cinema, shopping and the local pub.

We found there was no training matrix or other method used to ensure staff training was kept up to date and as such found several certificates were out of date. For example staff that had completed the emergency first aid at work training were required to have annual updates in January 2013 and 2014 however this had not been done. Infection control training had been carried out in 2012 with no refresher training carried out. These meant changes to practice had not been taught and therefore people may be at risk of receiving inappropriate care.

Requires Improvement

Is the service caring?

Our findings

We spent time observing people who used the service. We saw people were treated with respect and were spoken to courteously. There was an overall feeling of a home environment with people being encouraged to assist with daily tasks.

The provider had policies in place to ensure staff knew how to treat people with dignity and respect and were aware of their human rights. We saw one of the policies titled 'Handling and Storage of Medication' was dated 2002 and was copied from another larger document. The provider did not record when staff had read policies.

Everyone who lived in the home had their own private rooms. During our inspection we looked around the home and saw the doors to the bedrooms were closed and people who used the service had keys and could lock the doors if they wished. The communal bathrooms also had locks on the doors meaning people were given privacy when needed.

We looked at the daily diaries which were completed for people who used the service. These diaries showed information of concern regarding the management of toileting within the home. We asked the provider why people's toilet habits were monitored and if there were any medical concerns that made this necessary. The provider told us it was ensure people who used the service had cleaned properly and also to monitor stools to ensure they were healthy. This meant people who used the service were not being treated with dignity and were not being encouraged to be independent.

Information relating to the people who used the service was kept in people's care records. The care records contained personal information about people's medical conditions, financial matters and personal contacts and were kept in the lounge of the home. This meant people's privacy was protected because their records were not accessible to others.

The provider carried out meetings with people who used the service. These meetings were used so plans could be made for activities and outings they would like to participate in. One of the people who used the service recorded the details of the meetings in a notebook which was kept in the home. There were no formal minutes recorded but the notebook was available for others who used the service to view. Despite this the details of the meetings were not available in other formats and others in the service were not able to read what had been written as they weren't able to read.

Requires Improvement

Is the service responsive?

Our findings

Care plans contained information about people's medical conditions, the support they needed and how to provide this support there was also a family and friends page for staff to complete which was used to record family history. Of the care plans we looked at only one of these had been completed meaning staff hadn't taken the time to get to know the people they cared for and the people who were important to them.

We saw people's care plans contained information about referrals to other professionals in order to deal with health issues although there was little evidence of recommendations from professionals being put into practice. For example recommendations had been made regarding the communication needs of people living in the home but there was no evidence of these adjustments being carried out. In addition a letter found in the care record of one person had handwritten comments showed a disregard for the diagnosis and recommendations of the professional.

We looked at the assessments of needs that were recorded in people's care plans. We saw reviews were not carried out regularly and although people who used the service communicated with the staff, there was no record of the person's involvement in care discussions. We were told about one person who had suffered a serious health condition but when we looked at the care plan we found there was no information about this condition or how it affected their everyday needs and abilities. This is a breach of regulation nine because the provider failed to ensure the welfare and safety of the service user and reflect guidance issued by other professionals.

We found the provider did not routinely seek advice and support from professionals regarding people who used the service or their particular needs and this was evident from the support being provided with the people who used the service in that they were being cared for rather than enabled to live independent lives.

We asked how the provider dealt with people's sexual health and relationships. We were told none of the people who used the service had intimate relationships and this was not discussed. We did however receive information from the provider after our inspection which gave information regarding people's sexual orientation. There was no indication of how the provider established this information was correct.

The provider arranged for people who used the service to take part in various activities and outings. One of the people who used the service told us they liked to go out. We were told "I like to go to the pub and I go to art." The activities provided had been chosen by the people who used the service although staffing levels in the home meant activities were limited. Although this appeared to be working well this left no opportunity for people to opt for an alternative or even to stay in the home. This meant people were not being treated as individuals.

This breached Regulation 22 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider had failed to ensure there was enough staff on duty to meet the needs of people who used the service.

We saw monthly meetings were held with people who used the service where they were able to express their views about the service provided and saw evidence that changes had been made following these meetings.

We saw the provider had a visitor's book in the entrance to the home. This book could be used to make comments or complaints. When we looked at the book we found it was rarely used and people who visited the home did not routinely make comments.

The provider had a complaints procedure in place but there was no information displayed in the home about how people could make a complaint. This meant people who used the service, or those close to them may not be aware of how to make a complaint or provide feedback to the provider.

The provider had a service user guide which appeared to be cut and pasted from a local authority document and was not written or changed for the service or the people who used it.

Is the service well-led?

Our findings

We asked to see the quality assurance documents which applied to the home. We were told by the provider that there were no quality assurance audits available so we looked at records of maintenance for the home and the vehicle used to take people who used the service out.

We found the provider had a fire risk assessment carried out in April 2011 which gave details of risks to be addressed and any adjustments that needed to be made to the home. This assessment showed a suggested review date of April 2012 however we were told there had been no further risk assessments carried out. Since our inspection the provider has had a further fire risk assessment carried out which This assessment carried out in August 2014 was done by the same company as in April 2012 and highlighted areas of concern which had been noted on the previous risk assessment.

We found portable appliance testing has not been carried out regularly, and a comprehensive record of fire training, tests and checks were not being completed.

We found the provider had been issued a safety advice notice which related to the home's boiler dated May 2014 had not been acted upon and this was highlighted as a concern in the fire risk assessment dated August 2014. We also found a copy of a Food Safety Inspection record dated July 2013 which detailed required changes which had still not been actioned.

All these things meant people who used the service and the staff working in the home were at risk because equipment had not been properly maintained and tested.

This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider failed to ensure equipment in the home was safe.

We asked the provider to send us evidence of audits that were carried out to ensure the quality of the service. The provider told us they had no audits for infection control or maintenance, no accident and incident reviews and no emergency contingency plans. This meant the provider could not be sure of giving the best level of care.

This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider failed to regularly assess and monitor the quality of the services provided

We saw the provider had a vehicle which was used for the purpose of transporting people who used the service to various activities. We looked at the documents relating to the vehicle and found it was properly maintained however the insurance documents showed at the time of our inspection the provider did not have appropriate insurance for the vehicle. This meant if people who used the service were injured in an accident they would not be able to claim compensation for injuries they have sustained.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People who used the service were not given appropriate care because the provider had failed to pay follow advice given by professionals. 9(1)(b)(i)(ii)(iii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider failed to regularly assess and monitor the quality of the services provided 10(1)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The provider had failed to take appropriate steps to prevent the spread of infection. 12(1)(a)(b) (2)(c)(I)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The provider had failed to make suitable arrangements for the safe storage and administration of medicine**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

This section is primarily information for the provider

Action we have told the provider to take

The provider failed to ensure equipment in the home was safe by carrying out appropriate testing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider had failed to obtain proper consent to carry out care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider had failed to ensure there was enough staff on duty to meet the needs of people who used the service.