Benham Care Limited

Benham Nursing & Residential Home

Inspection report

217-221 Spital Road
Bromborough
Wirral
Merseyside
CH62 2AF
Tel: 0151 334 8533
Website: benhamcare@gmail.com

Date of inspection visit: 20 October 2014
Date of publication: 06/02/2015

Ratings

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

Overall summary

This was an unannounced inspection carried out on 20 October 2014. Benham Nursing & Residential Home provides accommodation and support with personal and nursing care for up to 43 people. The home mainly supports older people, some of whom also have dementia.

The home is a converted and extended period property with accommodation provided over three floors. Several lounge and dining rooms are available for people to use and all bedrooms provide single accommodation. A lift is available to enable people to access upper floors.

During the inspection we spoke with seven people who lived at the home, four of their relatives and six members

Summary of findings

of staff. We also spoke with the registered manager. 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 last inspected the home in April 2014. Following that inspection we asked the provider to take action to make improvements to how the quality of the service was monitored. The provider sent us an action plan to tell us the improvements they were going to make, which they would complete by 30 June 2014. During this inspection we looked to see if these improvements had been made, we found that they had not all been completed.

We found a number of breaches 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 this report.

Care plans did not provide sufficient information to inform staff about the person's health and personal care needs. Changes to people's care needs were not always reflected within their care plan.

Quality assurance systems within the home failed to identity issues we noted during this inspection. They also failed to improve areas of concern that the registered manager was aware of. This included poor medication management and staff culture and attitudes.

People were not protected from the risk of abuse. Incidents of potential abuse that had occurred had not been reported to the appropriate authorities for investigation under safeguarding adult's procedures.

Medication practices at the home were unsafe. People did not always receive their medication as prescribed or on time. Medication was not stored safely. Systems for checking medication had failed to improve practices in the home.

The majority of the people we spoke with told us that they liked the meals provided. We found that people were not always appropriately supported to eat their meals. No formal systems were in place to inform kitchen staff about people's dietary requirements.

People living at the home did not always have the equipment available to support them safely and with dignity. Equipment in use for people was not always managed in line with the guidance provided.

People living at the home and their relatives had mixed views about their involvement in their care. No formal system was in place for consulting with people about the care provided for them. Two people told us that they did not have a choice of the gender of the member of staff supporting them.

The home did not meet the requirements of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). No assessments of people's capacity to make decisions had been undertaken. The MCA and DoLS require providers to submit applications to a 'supervisory' body' for authority to restrict peoples liberty. Where people lacked the ability to make a decision about living at the home no application for a DoLS assessment had been made.

People living at the home told us that they felt confident raising concerns with the registered manager. However two relatives told us that they would hesitant to do so. There was no formal system in use for recording, investigating and responding to complaints. We saw no evidence that learning from complaints had resulted in changes to practices within the home.

Accurate care records were not always maintained for people living at the home. Records relating to individuals living at the home were not always stored confidently and changes made to records were not always legible.

Not all required records were obtained or available for staff working at the home. This included references and a Disclosure and Barring Service check. These records provide a way for the home to check the person is suitable to work with adults who may be vulnerable.

Staff were not deployed in a way that ensured people received the care they needed in a timely manner. People told us that at times there were not enough staff available to answer their call bell and provide the support they needed.

There were gaps in staff training particularly around the health needs of people living at the home. People living at the home told us that they did not think staff always understood the impact their condition had upon them.

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?

Inadequate

The service was not safe.

Staff were aware of the procedures to follow if they suspected abuse had occurred. However incidents of potential abuse were not referred to the appropriate authorities for investigation under safeguarding adult's procedures. This meant that independent investigations of potential abuse did not take place.

Medication was not safely managed within the home. People did not always receive their medication on time or as prescribed. Medication was not stored correctly increasing the risk of medication errors occurring.

Recruitment practices did not ensure that all of the required documentation was obtained for a member of staff before they commenced working at the home. This meant that not all of the checks that could be carried out on whether staff were suitable to work with adults who may be vulnerable had been undertaken.

At times there were insufficient staff available within the home to provide the support people needed with their health and personal care.

Is the service effective?

Inadequate

The service was not effective.

Assessments of people's ability to make decisions for themselves had not been undertaken. No referrals to a supervisory body for a Deprivation of Liberty Safeguard had been made. These safeguards help to ensure people are not being deprived of their liberty unduly and without proper safeguards in place.

People did not always receive the support they needed to eat their meals safely and well. Some of the people living at the home enjoyed the meals provided, others said that they did not always get the meal they needed or requested.

Equipment people required for their health and personal care was not always available or managed in line with best practice guidance.

Staff received training in basic areas of care. However they did not receive training in specific areas of care relating to the people living at the home. People told us they felt this impacted on the support they received from

Is the service caring?

Requires Improvement

The service was not caring.

Relatives told us they had always been welcomed when visiting the home. The people living there had mixed views of the support they had received. Some people felt it had been to a good standard, others that it could be improved.

Summary of findings

Staff were aware of the need to respect people's privacy and dignity and promote their independence. Some of the people living at the home had mixed views regarding this. Some people told us staff did not always listen to them about the effects their age and health had on their abilities. People also said that they were not always consulted and listened to about the care they received.

Is the service responsive?

Inadequate

The service was not responsive.

Care records were not updated as people's needs changed. We found differences between a person's care records, staff knowledge and what we observed. This could lead to people not getting safe care.

People living at the home felt confident to raise concerns with the registered manager. Relatives knew who to talk to if they had a concern but did not always feel confident to raise them. No formal system was in use within the home in regards to managing complaints.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance systems were insufficient to identify areas of concern. Where areas of concern had been identified systems were not robust enough to improve the quality of the service provided.

Records relating to people living at the home were not always well maintained and were not always stored confidentially.

Benham Nursing & Residential Home

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 checked 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 20 October 2014 and was unannounced. The inspection team consisted of an adult social care (asc) inspection manager, a lead asc inspector, a second asc inspector and a pharmacist inspector.

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.

Prior to our visit we looked at information sent to us by the registered manager since our last inspection in April 2014 and information sent to us by Wirral Social Services about the home.

During the visit we spoke with seven people living at Benham Nursing and Residential Home, four relatives, two nurses, two carers, the cook, three domestic staff and the registered manager. We observed care and support in communal areas. We looked at the premises and reviewed a range of records about people's care and how the home was managed.

These included care plans for four people, recruitment records for four members of staff, 10 people's medication records and quality assurance audits.

Inadequate

Is the service safe?

Our findings

Five of the people living at the home told us that they had felt safe living there. Two other people told us that at times they had not felt safe. One person explained this had been due to the way a member of staff had dealt with them. A second person told us that they did not always get their medication on time which had an impact on their health.

In discussions with staff they showed that they had an understanding of safeguarding adults. This included knowledge of the different types of abuse that can occur. Staff told us that if they had any concerns about potential abuse they would report it to the person in charge. In discussion with the registered manager they were aware of their duty to report potential safeguarding adult's incidents to the local authority and to notify CQC. However we found that this had not occurred.

We saw a record for one person living at the home which recorded that the person had told staff another staff member had spoken to them disrespectfully. There was no record that this had been referred to the local authority for investigation under Safeguarding adult's procedures. In discussions with a second person living at the home they told us they had informed staff and subsequently the registered manager about an incident in which they had been frightened by the way a member of staff had dealt with them. We discussed this with the registered manager who confirmed that no referral for investigation under safeguarding adult's procedures had been made to the local authority or notified to CQC. We referred both of these incidents to the local authority for investigation under their safeguarding adult's procedures.

Records written by the registered manager in June and August 2014 showed that he was aware medication belonging to people living at the home was unaccounted for. The registered manager did not report these incidents to the local authority for investigation under safeguarding adult's procedures until October 2014. The Local Authority visited the home in October 2014 to audit medications. As a result of this visit they made four referrals for safeguarding investigations. The registered manager had failed to identify and report these incidents. Investigations under safeguarding adult's procedures are on going regarding the issues identified with medication practices at the home.

These incidences were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because service users were not safeguarded against the risk of abuse as the provider had not taken reasonable steps to identify the possibility of abuse and prevent it before it occurred and had not responded appropriately to allegations of abuse.

We found appropriate arrangements had not been made in relation to obtaining medication. This meant that not everyone had an adequate supply of medicines so their medication had not been administered as prescribed and doses had been missed. We saw that when medication was not available nurses borrowed medication from other people and shared it between them. This meant that the people may run short of medicines they have "lent" to other people.

We saw that medicines were not administered safely. We found that when people were prescribed antibiotics they were not given the correct number of doses. If doses of antibiotics are missed then people's health is placed at risk of harm. One person told us they were not given their medication at the correct times of day because staff forgot and that made them worried and frightened they would suffer from unpleasant symptoms of their condition. Another person told us they were in pain on the day of the visit because they had not been given their pain relief on time. Records showed people had been given double the dose they were prescribed without any explanation. We saw that one person had been given too many Paracetamol. There was no indication that the overdose had been recognised or that any actions had been taken. These people's health had been placed at risk of harm.

People were prescribed medicines to be taken "when required" and we found that not all medicines prescribed in this way had adequate information available to guide staff as to how to give them. When information was available we found staff disregarded it and failed to give the medicines according to the information in their care plans.

We found that medicines were not stored safely. We found medicines stored in the fridge which should have been stored at room temperature. We found that no record had been taken of the temperature of the fridge, apart from on two days, for seven weeks. We also found that the container in which waste medication was kept was not

Inadequate

Is the service safe?

locked away. The manager told us he understood the importance of keeping waste medication secure. If waste medication is not kept secure it may be stolen or misused in some other way.

These incidences were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because service users were not protected against risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.

We asked to look at the recruitment records for a registered nurse who worked at the home. The registered manager advised us that this was locked away and he could not access it. He also advised that he had obtained verbal but not written references for this member of staff.

A recruitment file for a member of care staff contained only one written reference. No evidence that a Disclosure and Barring Service (DBS) check had been carried out on this member of staff was available. We asked the registered manager if this was stored elsewhere and he told us that all information should be contained within the recruitment file. References and a DBS check help to ensure that the applicant is suitable to work with people who may be vulnerable.

These incidences were breaches of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because effective recruitment procedures were not in place to ensure that persons employed were of good character and had the qualifications, skills and experience necessary for the work to be performed.

Six of the people living at the home told us that they did not think there were sufficient numbers of staff working at the home. They told us that staff were often busy and they had to wait for help. Three people told us that on occasions they had used their call bell to summon help and had to wait a long time for a member of staff to provide the support they required. One person told us that they knew what time staff had their breaks and therefore tried not to use their call bell at that time as they were aware they may wait some time before receiving a response. We saw times when there were no members of staff available in lounge areas. we also saw four occasions when visitors waited a long time for the door to be answered. This showed us that there were insufficient numbers of staff available to support people in the home at times through the day.

Relatives told us that at times they felt the home did not have enough staff. They said they had observed that staff were not always available when needed and that staff rushed around and appeared very busy. Staff told us that at times they had been short staffed. They explained that staff absences were sometimes covered by agency staff but not always.

These examples are breaches of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because there was not always sufficient numbers of staff employed to safeguard the health, safety and welfare of service users.

We observed that the environment was clean and tidy and there were sufficient bathrooms, lounge and dining areas available for people to have a choice of areas to use. Everybody living at the home had their own bedroom and the people we spoke with told us that they found their room comfortable.

A handyman was employed one day a week. He explained that any tasks or areas for repair were written down for him and this was then monitored by the manager. We noted that a carpet on the top floor had come away from its gripper rod. The handyman advised us that this had been repaired previously and had just recurred. This could cause a trip hazard for anybody using the stairs and was repaired during our visit.

Inadequate

Is the service effective?

Our findings

Several people living at the home told us that there had been no milk available that morning for them to have a cup of tea. One person told us that they had only been offered a drink of juice. Another person told us after lunch that they had not had a drink since breakfast time. The cook informed us that the milk order had arrived late that day; this meant no milk was available once breakfast drinks were served. Staff told that us that a shop was nearby. However nobody working at the home had made an attempt to purchase milk for people to have a hot drink.

The majority of people we spoke with told us that they liked the meals provided by the home and that they were offered an alternative if they did not like the main meal. Their comments included, "plenty to eat" and "lovely, I always like them." One person explained that they had chosen an alternative that day but had been given something else to eat. A second person told us that they did not think staff understood the restrictions their health condition placed on the food they could eat. We spoke with the cook who told us that there was no formal system in place for informing kitchen staff of any special diets people were on. This means that people may be provided with meals that are unsuitable for them.

We looked at a care plan for one person living at the home which recorded that they had dementia and staff had to act as the persons advocate for most aspects of care and communication. The care plan contained no evidence that an assessment of the person's capacity to make different decisions had been undertaken. As an individual's capacity can differ depending on the decision being made and their current health, it is important that mental capacity assessments are in place to help plan the support people may need with decision making.

The registered manager confirmed that no capacity assessments had been carried out for people living at the home. He also confirmed that no applications for a Deprivation of Liberty Safeguard (DoLS) had been made to the local authority for anybody living at the home. These safeguards are a legal way to ensure people are not deprived of their liberty unduly. The registered manager told us that the person whose care plan we examined would be 'a good candidate' for a DoLS but he had not applied to the local authority for a DoLS for the person. This meant the provider was not protecting people's rights by arranging for an assessment to be carried out which would test whether or not those people were being deprived of their liberty and whether or not that was done lawfully.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because suitable arrangements were not in place for obtaining, and acting in accordance with, the consent of service users, or the consent of another person who was able lawfully to consent to care and treatment on that service user's behalf.

Care records for one person showed that in June 2014 it had been identified they needed a specialist sling to help them use the toilet. We spoke to the person who told us that this sling had not been provided. As a result they were not always able to access the toilet safely and in a dignified manner. We discussed this with the registered manager who stated that he was aware of the need for this sling but was awaiting permission to purchase it from the provider.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because equipment was not available in order to ensure the safety of service users and meet their assessed needs and equipment was not always properly maintained.

Staff told us that they had received the training they felt they needed to carry out their role effectively. Training records showed that the majority of staff had received training in some areas of care. This included safeguarding adults, moving and handing people and fire safety. However we found that staff had not received more specialist training to support specific people living at the home. No training plan was in place to identify what specialist training was needed and how the home intended to provide this.

We observed a lunchtime meal using SOFI. We saw a member of staff supporting one person to eat their meal. The member of staff was giving the person their food quickly. As a result the person did not have time to swallow their food before being given a second spoonful. Another person living at the home told us that on occasions they had observed a member of staff giving another person living at the home their meal too quickly. This indicated to

Inadequate

Is the service effective?

us that staff did not have the skills or knowledge to support people to eat their meal safely and in a respectful manner. We reported our findings to the manager so that he could take action to address this issue.

We saw a care plan for a piece of medical equipment a person living at the home used. This stated that the equipment should be changed according to the 'standard procedure and protocol'. However when we asked the registered manager for a copy of this protocol he advised that they did not have one as District Nurses carried out this task. In discussions with the person's relative they explained that they had put a note in the person's room as they did not feel staff understood how to use the equipment safely and well. They told us that the equipment should be changed after 10 weeks but on one occasion it had not been changed for 13 weeks. Training records showed that staff had not received any formal training in the use of this piece of equipment.

Two people we spoke with told us that they did not think staff understood their medical condition and age and the effect this could have on them. Both people told us that staff expected them to do things they did not feel well enough to do. One person explained, "They don't give enough consideration to people who can't get around quickly. I try to help but I can't." The second person told us, "Staff say do it yourself, but I am getting older." They also explained that their medical conditions meant that they needed extra help at times and staff did not appear to understand this.

We asked the registered manager if staff had received training on this person's specific health condition and he advised us they had not. A lack of training for staff on how to understand the effects a health condition has on the person could lead to the person receiving unsafe or inappropriate support.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because staff did not receive appraisal training, supervision and professional development to enable them to deliver care and treatment to service users safely and to an appropriate standard.

Requires Improvement

Is the service caring?

Our findings

A relative told us that they had always been made to feel welcome and that there were no restrictions placed on them visiting their relatives at any time. Throughout the day we observed that visitors came and went freely to the home.

The people living at the home had mixed views about the care they received at the home. One person told us, “The girls are very good” and another person described staff as, “friendly.” Two other people living at the home were less positive with one saying the care they received, “could be better,” and another, “you get what you are given.”

Relatives told us that in their opinion staff respected people’s privacy and dignity. One relative explained that as far as they had observed personal care was provided in the person’s bedroom. In discussions with care staff they displayed an understanding of the need to promote people’s dignity. One member of staff explained they always explained to the person what was happening before providing personal care. Another member of staff explained they always ensured doors were closed and knocked before entering a room. During our visit we observed that staff knocked and obtained permission before entering people’s bedrooms.

Three relatives told us that to their knowledge they or the person had not been asked if they had a preference for the gender of the person who supported them. One of the people living at the home told us they had been asked and had said they preferred female staff to support them. However they explained sometimes a male carer provided their support. Another of the people living at the home told us that they had not been asked explaining they “get whoever is on duty.”

Relatives had mixed views about their involvement in planning their relatives care. One person told us they had been initially asked for their opinion; a second relative told us that they had been asked and a third relative that they had not. One of the people living at the home told us that they had been involved but “not for a while.”

Care staff displayed an understanding of the need to support people to maintain their independence. One member of staff explained that they try to encourage people to do as many tasks for themselves as possible. However two of the people we spoke with felt that staff expected too much of them without understanding the effects of their medical condition on their ability to carry out tasks for themselves.

These incidences were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because service users were not enabled to make, or participate in making, decisions relating to their care or treatment.

Inadequate

Is the service responsive?

Our findings

Relatives told us that they did not observe many activities taking place at the home other than people watching television. One of the people living at the home told us, “Nothing goes on here. Activities on a Monday but who wants to play bingo.” A second person told us, “We do nothing all day. Saw the same film this morning as last night.” Throughout our inspection we did not see any arranged activities taking place or any occupation provided for people other than watching television.

We observed two people sitting in the lounge wearing bed socks. Staff told us that one of these people walked with a walking frame, the second person walked with support from a member of staff. No assessments were available in their care plans to assess the safety of them wearing bed socks when walking. This could lead to the person being unsteady on their feet and therefore having an accident. Care records for the first person stated that they walked independently. No mention was made of the use of a walking frame. Records for the second person stated that they were not mobile and needed to use a hoist. This meant that the discrepancy between staff knowledge and written records could lead to people receiving unsafe or inappropriate support.

We looked at care records for one person who had a skin wound. There was no written guidance in place to state the type of dressing being applied. Records did not give sufficient detail on the current condition of the wound. This means that there was insufficient detail available to assess whether current treatments were effective and to guide staff on the treatment required.

These incidences were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because service users were not protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of the carrying out of an assessment of the needs of the service user; and the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service user’s individual needs and ensure the welfare and safety of the service user.

Three of the people living at the home and four of their relatives told us that they knew who to talk to if they had a concern or complaint. One relative told us they had raised a concern and had been listened to, however they had not received a written reply to their complaint. The people living at the home told us they would talk to the registered manager and that they were confident he would listen to them.

A person living at the home told us about an incident that had occurred in which they had been upset by the way in which a member of staff had spoken to them. The registered manager told us that he had looked into this matter. However no feedback on the outcome of his findings had been given to the person who raised the concern. Two of the relatives we spoke with told us that they did not like to raise concerns. One said they did not like to ‘make waves’ the second said that they were worried it may lead to repercussions for the person living there.

Minutes of a staff meeting dated 4 August 2014 showed that the registered manager had raised with staff a complaint he had received from a visiting professional stating that staff had spoken to people living at the home ‘possibly rudely.’ The registered manager told us that he had dealt with this. However during the inspection we spoke with one person who told us that on occasion staff talked over them and did not listen to them. This indicated to us that the issue of staff attitude raised as a complaint and subsequently at the staff meeting had not been resolved.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because an effective system was not in place for identifying, receiving, handling and responding appropriately to complaints and comments made by service users, or persons acting on their behalf.

Prior to being admitted to the home an assessment of the persons care needs had been carried out. This helps to ensure sufficient information is when the person arrives at the home available to plan the support they need.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager in post. This is a condition of the registration of the home. The other conditions for registration had also been met.

All of the relatives and people living at the home that we spoke to told us that they knew who the registered manager was. They all told us that they found him approachable. Care staff also told us that they found the manager approachable and that he listened to their opinions.

On the day of our inspection the manager had been on holiday the previous week and was on the rota to work a night shift. This meant that he would not be available to speak with other agencies who had been dealing with medication concerns within the home. The registered manager did attend the inspection and alternative cover was arranged for the night shift. The manager explained that he did not write the rota and at times he was given shifts to cover staff shortages. This indicated to us that the registered manager's time was not always effectively managed to ensure he was available to lead the home.

No formal systems were in place at the home to obtain the view of people using the service, their relatives or visiting professionals. We asked for records relating to any surveys or resident / relative meetings that had taken place, these were not provided. People living at the home and their relatives told us that they had not had the opportunity to attend any residents and relatives meetings. They also told us that they had not received any formal questionnaires seeking their views of the service provided. Two of the people living at the home told us that the registered manager had informally asked them their opinion of the care they had received. They said that he had listened to their point of view.

We saw a document dated 6 June 2014 which recorded that the registered manager had suspicions medication was going missing, however he did not report this to the local authority until October 2014. The local authority then carried out an audit of medications in the home and found a number of serious concerns. This included medication unaccounted for and poor storage of medication. We looked at medications during this inspection and found management of medications remained unsafe. This included medication that was unaccounted for and medication not given as prescribed. This showed us that the provider did not have effective systems in place to identify, assess and manage risks relating to the health, welfare and safety of people living at the home.

During the inspection we asked to look at audits of care plans. We saw that these had not been completed since August 2014. We saw records for two people who had skin wounds. No specific care plans were in place to guide staff on how to treat these. Care records for one person stated they had sustained a fracture and must not be placed on their right side. Their care records had not been updated to reflect this. This showed us that systems in use at the home for assessing and monitoring the quality of the care provided were ineffective.

During the inspection a relative and a person living at the home told us that they were aware of the times staff took their breaks and tried not to use their call bell during these times. They said it could take a long time to receive an answer. Following the lunchtime meal we observed staff taking a break, we also observed a period of fifteen minutes when no staff were available in either lounge on the nursing unit of the home. This showed us that systems in the home for monitoring the deployment of staff and the culture within the home were not effective.

These incidences were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because service users were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided and to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk.

In one lounge we observed files relating to peoples medication and daily support stored on a trolley. No staff were in the room and these files were accessible to people living at and visiting the home. They contained information about people's health conditions and personal care. This meant that their right to confidentiality may be beached.

One care plan that we saw contained entries that had been written and then crossed out. This meant the entry could

Inadequate

Is the service well-led?

no longer be easily read. Guidance on good record keeping from the Nursing and Midwifery Council states that if a record requires altering then it must be clear and auditable signed and dated.

These examples are breaches of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because service users were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in relation to the care and treatment provided and records were not kept securely.

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 **Service users were not protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of the carrying out of an assessment of the needs of the service user; and the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service user's individual needs and ensure the welfare and safety of the service user. Regulation 9 (1) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **Equipment was not available in order to ensure the safety of service users and meet their assessed needs. Equipment was not always properly maintained. Regulation 16 (1) (a) (2)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Service users were not enabled to make, or participate in making, decisions relating to their care or treatment. Regulation 17 (1) (b)**

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

This section is primarily information for the provider

Action we have told the provider to take

Suitable arrangements were not in place for obtaining, and acting in accordance with the consent of service users, or the consent of another person who was able lawfully to consent to care and treatment on that service user's behalf. Regulation 18 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints An effective system was not in place for identifying, receiving, handling and responding appropriately to complaints and comments made by service users, or persons acting on their behalf, in relation to the carrying on of the regulated activity. Regulation 19 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Service users were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in relation to the care and treatment provided. Records were not kept securely. Regulation 20 (1) (a) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Effective recruitment procedures were not in place to ensure that persons employed were of good character and have the qualifications, skills and experience which are necessary for the work to be performed. Regulation 21 (1) (a)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There was not always sufficient numbers of staff employed to safeguard the health, safety and welfare of service users. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Accommodation for persons who require nursing or personal care Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010. Supporting workers Staff did not receive appraisal training, supervision and professional development to enable them to deliver care and treatment to service users safely and to an appropriate standard. Regulation 23 (1) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 provision Service users were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this part of these regulations; and identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity

The enforcement action we took:
We have served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Service users were not safeguarded against the risk of abuse by means of taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; and responding appropriately to any allegation of abuse.

The enforcement action we took:
We have served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Service users were not protected against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate

This section is primarily information for the provider

Enforcement actions

arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

The enforcement action we took:
We have served a warning notice.