Southwark Park Nursing Homes Limited

# Blenheim Care Centres

## Inspection report

Hemswell Cliff
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21 September 2016

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |
| Is the service safe? | **Inadequate** |

# Summary of findings

## Overall summary

We inspected Blenheim Care Centres on 21 September 2016. The inspection was unannounced.

Blenheim Care Centres is a nursing and residential care home for up to 80 people located near Gainsborough, West Lincolnshire. The care centre is divided into three units, Blenheim House, Blenheim Lodge and some semi-independent flats. Blenheim Lodge was closed for refurbishment on the day of the inspection.

The centre caters for people whose ages range from 18 years and above, and who have physical disabilities and/or neurological conditions. On the day of our inspection 28 people were living at the care centre.

A newly appointed manager was in post who had not yet registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 carried out an unannounced comprehensive inspection of this service on 9 August 2016 during which breaches of legal requirements were found. We told the registered provider that they must become compliant with Regulation 12 (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment by 31 August 2016.

We undertook this focused inspection to check that the provider had taken action to ensure that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Blenheim Care Centres on our website at www.cqc.org.uk.

At this inspection we found that the registered provider had not made all of the improvements required to ensure they were compliant with legal requirements.

Improvements had been made to the way in which some medicine supplies were recorded. However, there were continued shortfalls in the recording of medicine stock levels, medicines administration and the

transcribing of medicine prescriptions. In addition, there were no systems in place to ensure shortfalls would be identified and rectified in a timely manner.

Improvements had been made to the way in which some risks to people's health, safety and welfare had been managed. However, risks for some people had not been identified and planned for despite previous experience of issues arising as a result of those risks not having been appropriately managed. Risk assessments and management plans that were in place did not provide sufficient detail to enable staff to monitor the level of risk or to provide the care and treatment required to minimise the risks.

We are currently taking action against the registered provider to ensure that they make the necessary improvements to become compliant with legal requirements.

## 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.

Medicines were not managed in a safe way.

Risks to people's health, safety and welfare were not robustly managed.

We could not improve the rating for this key question from inadequate because the provider had not made sufficient improvements to meet the legal requirements.

# Blenheim Care Centres

**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. We undertook an unannounced focused inspection of Blenheim Care Centres on 21 September 2016. This inspection was carried out to check that improvements to meet the legal requirements about the management of medicines and risks to people using the services following our comprehensive inspection on 9 August 2016 had been made.

We inspected the service against one of the five questions we ask about services: is the service safe. This was because the service was not meeting the legal requirements in relation to that question. We had told the registered provider that they must become compliant with Regulation 12 (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 31 August 2016.

The inspection team consisted of an adult social care inspector and two pharmacy inspectors. During the inspection we looked at four people's care records and the medicine administration records (MAR's) for five people. We also spent time observing how staff provided care for people to help us better understand the support people received.

Before the inspection we looked at the information we held about the home such as notifications, which are events that happened in the home that the provider is required to tell us about, and information that had been sent to us by other agencies such as service commissioners.

We spoke with two members of care staff and two registered nurses. We also spoke with the manager and the registered provider organisation's area manager.

Inadequate

# Our findings

At our inspection on 9 August 2016 we found the registered provider had not ensured that people would receive their medicines in a safe and consistent manner. In addition, the registered provider had not ensured that risks to people's health, safety and welfare had been suitably assessed, managed and reviewed. This was a breach of Regulation 12 (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

At this inspection we found that medicines were stored securely in a locked treatment room and access was restricted to authorised staff. Unwanted medicines were disposed of in accordance with waste regulations. However, medicines that required extra checks and special storage arrangements because of their potential for misuse were not always managed correctly. These medicines are referred to as controlled medicines. The medicines were stored in a separate controlled medicines cupboard; access to them was restricted and the keys were held securely. However, some of the records had not been completed correctly; for example, one entry stated some controlled medicines had been destroyed, but we found they were still in the controlled medicines cupboard.

Room temperatures where medicines were stored were recorded daily; however temperatures had been recorded above the recommended limit for storing medicines on eight days in August 2016 and two days in September 2016. Staff had not taken any action in response to this and the manager had not carried out a risk assessment for storing medicines outside of the manufacturer's recommended temperature limits. We checked medicines which required cold storage and found temperatures had been recorded outside of the recommended range on 12 occasions in August 2016 and five occasions in September 2016. No action had been taken by staff and the manager had not been informed. This meant we could not be sure these medicines were safe to use. In addition, a registered nurse we spoke with did not know the recommended temperature range for medicines requiring cold storage.

At our previous inspection in August 2016, we identified discrepancies with the recording of stock balances of medicines and this remained a concern during this inspection. Although improvements had been made in the recording of medicines supplied in monitored dosage systems, we found discrepancies in all of the stock sheets we reviewed for medicines supplied outside of the monitored dosage system.

We found medicine administration records (MAR's) were not completed accurately which had also been identified during our inspection in August 2016. We found omissions in signatures in three on the five records we reviewed. In addition, one person's MAR had been handwritten; we found the dosage of one

medicine had been incorrectly transcribed. A second check had not been carried out by nursing staff to confirm the dosage instructions had been transcribed accurately. In addition, this person was prescribed a pain relief patch which had not been recorded on the MAR despite it being applied while they were living at the service.

There was a lack of written guidance to enable staff to safely administer medicines which were prescribed to be given only as and when people required them, known as 'PRN'. For example, one person was prescribed a medicine to stop epileptic seizures but there was no guidance to indicate exactly when this may be required. Another person was prescribed a medicine used to treat anxiety; nursing staff could not describe the behaviours this person might display which would indicate the medicine should be given and there was no written guidance to support safe administration. In addition, staff did not record the reasons for administration so it was not possible to tell whether these medicines had had the desired effect. Some medicines were prescribed with a variable dose, for example one or two tablets to be given. We saw the quantity given was not always recorded meaning that records did not accurately reflect the treatment people had received.

There was a lack of oversight with respect to medicines management and no system of audit to drive forward improvements. We were told medicines audits should be carried out weekly; however the manager could not provide us with any completed audits or actions resulting from identified concerns.

At this inspection we found that some risks to people's health, safety and welfare had been identified and planned for. An example of this was the way in which management plans for a person who was at risk of experiencing raised or lowered blood glucose levels had been written. There was clear information about how staff should support the person with these issues. However, the management plan indicated that staff should carry out certain checks on a daily and a monthly basis in order to monitor the person's wellbeing. A registered nurse we spoke with was not aware of all of the checks required and could not provide us with any documentation to show that other nurses had carried out the required checks.

We found that some risks had not been identified in people's care records. An example of this was in relation to the risk of developing an infection of the blood, known as sepsis. This was despite two recent occasions in which sepsis had been diagnosed by healthcare professionals. There were no management plans in place for those who were at increased risk of developing the infection. There was no information available for staff to enable them to identify signs or symptoms of the condition at an early stage so as a person may receive timely medical care. A registered nurse we spoke with was not able to accurately describe the signs and symptoms of sepsis. The registered provider had not taken account of good practice guidance in regard to sepsis such as having regular sepsis monitoring systems in place.

Where risk assessments had been carried out and management plans developed they were not always robust or effective. We saw an example in which a person had been identified as being at risk of choking. The risk management plan identified only that the person should be supported by staff to eat and drink. There were no clear instructions as to how food and drink was to be prepared for the person or whether the person required specialist equipment to help them eat and drink. Furthermore there were no instructions for staff as to how they should respond in the event of the person experienced choking.

In addition, we saw a person had been identified as being at risk of developing pressure ulcers on key areas of their body as they were unable to move independently. The risk management plan indicated only that staff deliver regular pressure relief and carry out daily skin checks. There were no clear instructions as to how staff should provide the pressure relief or if specialist equipment was required to enable this. In addition, we did not find that staff had consistently recorded that pressure relief had been carried out or what the

condition of the person's skin was. However, the manager, a registered nurse and two care staff confirmed to us that no one who lived in the home currently had any problems with their skin as a result of pressure damage.

We saw the risk assessments and management plans for two people who experienced epileptic seizures. These records did not indicate information such as what type of seizure the people experienced, what their usual recovery pattern was or what harm could occur if seizures were not managed appropriately. Furthermore, the risk management plan did not specify what actions staff should take if the people experienced a seizure.

Continued shortfalls in medicines and risk management arrangements meant that people were at risk of not receiving care and treatment in a timely and consistent manner.

This was a continued breach of Regulation 12 (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.