Benham Care Limited

# Benham Nursing & Residential Home

**Inspection report**

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |
| Is the service safe? | Inadequate |
| Is the service well-led? | Inadequate |

## Overall summary

We carried out an unannounced comprehensive inspection of this service on 20 October 2014. Breaches of legal requirements were found. As a result we undertook a focused inspection on 21 January 2015 to follow up on whether action had been taken to deal with the breaches.

**Focused Inspection of 21 January 2015.**

Following the inspection we carried out on 20 October 2014 we served three warning notices for breaches of legal requirements. These related to breaches of the following regulations.

Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities).This was because service users were not safeguarded against the risk of abuse.

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.

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 to regularly assess and monitor the quality of the services provided.

# Summary of findings

The warning notices stated that the provider and manager must become compliant with these regulations by 31 December 2014. We undertook a focused inspection to check that they had met these legal requirements and found that they had not.

During the inspection we spoke with five people who lived at the home, one of their relatives and two members of staff. We also spoke with the registered manager and provider.

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

People were not protected against risks associated with the unsafe use and management of medicines People did not always receive their medication as prescribed or on time, records about people's medication were not always accurate and medication was not stored safely. Medication practices at the home were unsafe.

Quality assurance systems within the home were not robust enough to identify and improve areas of concern that had been highlighted within the warning notices. This included the lack of a system in use for auditing care records. This meant that there was no reliable system in place to check whether people were getting their planned care and to ensure that care was effective. We also found that quality assurance systems failed to ensure people's medication was managed safely.

# 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.

An incident of potential abuse was not referred to the appropriate authorities for investigation under safeguarding adult's procedures. This meant that independent investigations of potential abuse did not always take place.

People were not protected against risks associated with the unsafe use and management of medicines.

People did not always receive their medication as prescribed or on time, records about people's medication were not always accurate and medication was not stored safely.

Medication practices at the home were unsafe.

**Is the service well-led?**

Inadequate 

The service was not well led.

Quality assurance systems were not robust enough to identify concerns with and effectively manage medication practices safely.

There was no effective system in place to ensure people received their care as planned and to assess whether that care was effective.

# 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. The inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Benham Nursing and Residential Home on 21 January 2015. This inspection was carried out to check that the provider and manager had meet legal warning notices we had served on them following our comprehensive inspection which took place on 20 October 2014. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led. This is because the service was not meeting some relevant legal requirements.

The inspection was undertaken by an Adult Social Care (ASC) manager, an ASC lead inspector and a pharmacist inspector. During our inspection we spoke with five of the people living at the home, a relative of one of the people living there and four members of staff including the registered manager and provider. We looked at medication records and observed medication practices. We also looked at care records relating to the people living at the home and at records relating to quality assurance systems.

Inadequate

# Is the service safe?

## Our findings

We saw one person living at the home who had extensive bruising to their face and right arm. The registered manager told us and records confirmed that this person had fallen. We asked the registered manager if the incident had been referred to the local authority under safeguarding adult's procedures. He stated that he did not consider this a safeguarding adult's incident and had therefore not made a referral. No notification of the incident had been sent to the Care Quality Commission (CQC). Failing to notify the appropriate authorities of potential incidents of harm or abuse means that an independent investigation of the incident will not take place. During the inspection we asked the registered manager to make a referral to the local authority regarding this incident and he later confirmed that he had done so.

This incident was a breach 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.

We found that since our last inspection some very limited improvements had been made in regards to medicines. One person living at the home told us that in their opinion, their medication was now managed "Much better." They said, "They (staff) understand how important it is to get medication. A great stride forward." We also found that appropriate arrangements were in place in relation to obtaining medication and everyone had an adequate supply of medicines.

We found that appropriate arrangements were still not in place in relation to the recording of medicines. Medication Administration Records (MAR) sheets are signed to indicate that the person has been given and has taken their medication. We saw that the nurse on duty signed the records for people's medicines before they were given. We saw the nurse left medicines in front of one person which they did not take, but the nurse signed the records to indicate they had been administered. Signing prior to the person taking their medication means that there is no reliable audit trail of the medication the person has taken.

We found there were still gaps on the records where staff had failed to sign to show medicines had been given so it was not always possible to tell if people had been given their medicines properly. We found records made about the application of creams did not show creams were applied properly and there were still no records made about the use of thickeners in people's drinks. The records made in the controlled drugs register were incomplete. Full records must be kept to ensure all medicines are accounted for and used as prescribed.

We saw that some additional arrangements to ensure that medicines could be accounted for had been put in place. We found that these arrangements failed to ensure that medicines could be properly accounted for. We saw there was a discrepancy about the quantity of Warfarin in the home for one person and the home had reported to us a loss of a significant quantity of some strong analgesic tablets. We saw that the quantities of drugs recorded in the controlled drug register were not checked on a regular basis, so it was not possible to ensure that these strong medicines were properly accounted for. If medicines cannot be accounted for people's health may be placed at risk because of the risk of misuse.

We saw that medicines were still not administered safely. We found the system in place to ensure that doses of medicines were not given too close together was ineffective. One person was given doses of Paracetamol too close together on three occasions on three different days. We saw another person was given Paracetamol despite records indicating they were not in pain. One person told us that they had to ring their call bell to ask for their medicines because the nurse had not brought them all their due medicines at the right time. We saw that nurses failed to apply eye drops at the prescribed time and the person had to wait more than an hour for them. We also found that when we examined the stock together with the records that people had not been given all the doses of their inhalers which had been signed for. The records showed that one person was given some pain relief that was out of date. If people are not given their medicines safely their health could be at risk.

We saw people were not given antibiotics properly, one person was given too few doses of their antibiotic eye drops over a period of 13 days and another person was not given their antibiotics at the right time. They were given the antibiotic with food instead of two hours before food; this means their health was at risk because the antibiotics may not have been fully effective.

Inadequate

# Is the service safe?

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. We found there was still no information recorded to guide staff which dose to give when a variable dose was prescribed. It is important that this information is recorded to ensure people were given their medicines safely and consistently at all times. We found there was only limited guidance in place to help staff apply creams appropriately.

During our inspection of 20 October 2014 we had drawn the registered manager's attention to the fact that the container for medications to be returned to pharmacy was not secured. During this inspection we saw that the container remained unsecured. Medication for return to pharmacy was stored in a bin with an open lid, within the medication room; the medications were readily available to anyone with access to the medication room. This meant that there was the potential for medication to be stolen or misused in some way.

Inadequate

# Is the service well-led?

## Our findings

We asked the registered manager to provide us with copies of any care plan audits carried out since our inspection in October 2014. He informed us that no audits of care plans had taken place since August 2014. This meant that there was no effective system in place for auditing and monitoring the quality of the care and treatment people received.

We saw a care plan for one service user written in February 2014 which stated that she was able to walk with the support of carers and a walking frame. We spoke to the person and to staff about the support the person required. They told us that the person was unable to walk. This means that guidance to staff on how to support the person was inaccurate and could impact on the support they received.

A care plan for a second person written in December 2014 recorded that they had lost weight and were at high risk of malnutrition. The plan stated that they were to be referred to the dietician, their GP should be informed, records of their intake of diet and fluids should be recorded and they should be weighed weekly. An evaluation of the plan dated January 2015 stated, 'continue as per plan'. Records showed that the person had been weighed once since the plan was written and not weekly. We saw records of fluid and food intake but these were incomplete. We saw no record within the person's care plan that referrals to the dietician had been made or that a fortified diet was being given. This means that there was no effective way to monitor the person's risk of malnutrition and to assess whether the planned treatment was being delivered and was effective.

We had identified during our October 2014 inspection that a person living at the home had a wound to their leg but care plans were insufficient to guide staff on how to treat the wound. The persons current care plan stated in December 2014 they had a wound to their leg. However, no record of the condition of the wound or the treatment to be given, was recorded. We saw that a box of dressings was available for this person and noted that ten of the twelve dressings were not in the box. No records were available to state who had applied the dressings and when. The Registered Nurse working at the home on the day of our visit told us that they had applied a dressing to this persons' wound previously. At our request they checked the person and told us the person currently had a dressing in place. The lack of clear recording meant that there was no reliable method in use to assess whether the current treatment was being carried out as prescribed and was effective.

We found that systems for monitoring medication practices in the home were not robust enough to ensure people received their medication safely and as prescribed. This included, medication being signed for prior to the person taking it, medication not being given at the times and frequency of prescription and medication not being stored safely.

The manager had recently reported to the local authority that 50 pain relief tablets were unaccounted for. This had been identified over a weekend, however a check was not carried out until the following Wednesday. By this time a number of people had been responsible for dispensing medication. This meant that while the auditing system was sufficient to identity missing medications it was not robust enough to audit exactly how and when they had gone missing and who was responsible for this.

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.