Benslow Management Company Limited

Benslow Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection was carried out on 10 November 2015 and was unannounced. We inspected the service in response to concerning information we had received about the care people received. We found the concerns to be accurate and people had not consistently received good care at Benslow Nursing Home.

Benslow Nursing Home provides accommodation and personal care for up to 30 older people, some of who live with dementia. There were 28 people living at the service on the day of our inspection. There was a registered manager in post. 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 and associated Regulations about how the service is run.

When we last inspected the service on 13 May 2015 we found them not to be meeting the required standards in relation to the management of medicines. At this inspection we found that they had addressed the issues in relation to medicines and they were now managed safely.

CQC is required to monitor the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS

Summary of findings

are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection applications had been made to the local authority in relation to people who lived at the service. The manager and staff were fully aware of their role in relation to MCA and DoLS and how people were at risk of being deprived of their liberty. However, we noted that one person may have been unlawfully deprived of their liberty due to the use of bed rails.

People's care needs were assessed and documented. However, care was not always provided in accordance with these needs, training or guidance and as a result people were at risk of inappropriate and potentially unsafe care. Staff were aware of people's needs but there were gaps in training provision.

People's weight and health was monitored. However, there were concerns in relation to the risk of missed meals and fluids. We also found concerns in relation to the use of pressure relieving equipment as mattresses were not set correctly and cushions were not in use where they were required. People were on their own in their room for long periods of time with limited engagement from staff and consideration to the environment, such as lighting and things to occupy people were not considered by staff.

There were systems in place to monitor the quality of the service. However, they were ineffective as they had not identified all the concerns we found during our inspection.

We found that the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we took at the back of this report.

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.

People did not always receive care in accordance with their assessed needs.

Equipment was not always used safely.

There had been staff vacancies which affected the staff team's morale.

Medicines were managed safely.

Requires improvement

Is the service caring?
The service was not caring.

People were not always treated with dignity and respect.

Staff did not always ensure people's whole needs were met and there was limited engagement between staff and the people they supported.

Requires improvement

Is the service responsive?
The service was not responsive.

Staff did not always ensure people's individual care needs were met.

Requires improvement

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

There were systems in place to monitor the quality of the service. However, they did not identify all the issues found during the inspection.

The values of the management team were not shared by the staff team.

Requires improvement

Benslow Nursing 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 was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This visit took place on 10 November 2015 and was carried out by one inspector. The visit was unannounced. Before our inspection we reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with five people who lived at the service, four members of staff, the regional manager and the registered manager. We received feedback from health and social care professionals. We viewed three people's support plans. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Requires improvement

Is the service safe?

Our findings

When we inspected the service on 13 May 2015 we found that people's medicines were not always managed safely. At this inspection we found that the shortfalls had been addressed and this standard was now met. We saw that medicine records were completed consistently and handwritten entries were countersigned. Boxed and bottled medicines were dated on opening and there was a list of staff signatures. Nursing staff had been carrying out regular checks on stock and when we checked the quantities of medicines against the records, the correct amount of tablets were in stock. This helped to ensure that people received their medicines in accordance with prescriber's instructions.

People told us they felt safe living at the service and staff knew how to raise and report any concerns. However, we noted that some practices observed on the day of our inspection did not keep people safe. For example, we observed staff moving one person in an unsafe way up their bed instead of using the correct lifting equipment. We also noted that one staff member who lifted this person came into the room with a pair of gloves on and then went to deliver care to another person without changing their gloves or washing their hands. This lack of good hygiene practice increases the risks of infections.

People had individual risk assessments for all aspects of their care. We saw that these were communicated to staff through meetings and handovers. We saw that risks in relation to dehydration were monitored and nurses reported concerns relating to a person's fluid intake to the GP. A visiting health care professional told us that they felt the staff were good at identifying and reporting any concerns about people's health and followed any guidance appropriately.

However, we saw that other areas, such as pressure care was not consistently managed. We saw that people who needed it were supported to change position at regular intervals but their pressure care equipment was not always used safely. For example, we checked three pressure relieving mattresses and found that they were all at the wrong setting for people's weight. In addition, one person, who was assessed as very high risk of developing a pressure ulcer, had not been sitting on the required pressure relieving cushion for over four hours when we brought it to the manager's attention. We also saw that a person assessed as not to have bedrails installed, due to the risk of them attempting to climb them, had bed rails in use on the day of our inspection. One rail had a bumper and staff told us they had installed this as the person leaned that way and they wanted to prevented them falling from bed. The other rail was without a bumper and staff told us that night staff put it up but were unable to give an explanation as to why they would do that. We noted that this person was prone to behaviour's which included frequently walking around, which at times escalated into a state of heightened anxiety. These behaviours were not noted during the night time hours.

People were at risk of missing their meals due to staff not adhering to the appropriate recording system in place. We found that although staff signed to say they had provided people with meals on the day of our inspection one person had not received their meal. When questioned staff were unable to tell us if they had ensured this person had received their lunch and admitted to falsely completing the records. This meant that had we not brought it to their attention, this person would have missed their main meal of the day.

The risks associated with the improper use of pressure relieving equipment and bed rails, poor moving and handling techniques and the risk of neglect due to missed meals was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) 2014.

People told us that they felt there was enough staff to meet their needs. One person told us, "When I press the bell they come." Another person told us, "They come quite quickly if they're not busy with someone else." However, a third person told us that staff did not always come when they called. The person told they thought it was because they called frequently and said, "They probably think it's only [name]." We reviewed the call bell which was unable to be reset without going to the room which had called. The manager told us they checked how long it takes for staff to answer a bell by activating it and timing staff response. They said calls were responded to, "In around four minutes on average." We noted that some people were unable to use their call bell so hourly checks were in place to monitor them. The manager told us that they had suffered with staff vacancies over the past few months and although they had covered the shifts with returning agency staff, they felt it had impacted on the moral of the staff team. There was ongoing recruitment at the time of our inspection.

Requires improvement

Is the service caring?

Our findings

People told us that the staff were nice but they felt lonely. One person told us, "It's nice to hear a human voice and not the TV." We noted that staff went quickly in and out of rooms without taking the time to talk with people beyond what was necessary, for example, "Here's your lunch." We found that even when care was being provided, bedrooms were silent with little to no communication between staff and the people they were supporting.

There was limited engagement with people and their whole needs were not being met. We found that subtle care needs such as cleaning glasses and nails, brushing hair and turning a light on in a dark bedroom where not met. We also saw a person drinking from the wrong bit of a beaker and missing the spout but staff didn't intervene or notice their struggle. Many people spent long periods of time on their own in their bedrooms. Staff told us that this was their preference and some people were cared for in bed. The manager and regional manager told us that on a different day more people may be in the communal areas.

However, we discussed with the manager our concerns that people were not offered the choice of coming out of their rooms or bed and as a result were at risk of becoming isolated, particularly as staff interaction was limited.

Our observations showed that at times people were not always treated as individuals and care provided was task orientated rather than person centred. We did note that one person was purchased an aid to enable them to maintain some independence and ability to go out alone. However, this was not throughout the home and the staff culture was not the same as the managers and that of the provider. For example, when one person said they were hungry and had not eaten lunch yet, a staff member disregarded the comment and said, "They've got dementia and they've forgotten." This did not demonstrate concern or care and instead indicated that their voice may not be heard. We also saw that a staff member was sitting eating a dessert while they were expected to be working and a person had their meal sitting in their room and they were waiting for assistance to eat from this staff member. This did not demonstrate a people first culture.

This was a breach of Regulation 10 of Health and Social Care Act (Regulated Activities) 2014.

Requires improvement

Is the service responsive?

Our findings

People told us that staff met their needs but were unable to elaborate on how they were supported. One person said, "All very good."

We saw that when people developed a skin tear or pressure ulcer, the nurses developed a short term care plan to detail the care needed.

Relatives had raised concerns with us in relation to continence care at the service and they were worried that people were not receiving the appropriate support. We noted that the environment smelled fresh and people did not appear to be wet or soiled. However, we saw that records may not have reflected the care provided. For example, one person's records in their room stated that they had last received continence care at 9.15pm, almost 12 hours prior to our inspection. However, the care notes in their care plan recorded a summary of the hours between 8pm and 8am and they stated continence care was given. It was not clear if the notes referred to the 9.15pm support or additional interventions. We also saw that this person was extremely dry around and in their mouth and they told us they felt, "Very dry." There was no record of fluids being offered, there was only a summary of the day shift which had ended the previous day at 8pm. We brought this to the manager's attention who commenced a fluid chart for this person as their care plan stated they required encouragement to drink.

Care plans were written in a way that provided staff with clear guidance on how to support people appropriately and safely. However, we observed staff supporting people and found that they did not always support people in accordance with their assessed and recorded care needs. For example, not removing a person's dentures at night as requested, appropriate use of pressure relieving equipment and moving and handling techniques. When asked, staff were able to describe people's needs but did not consistently work in accordance with them.

As a result people did not receive care that met their individual needs, therefore this was a breach of Regulation 9 of Health and Social Care Act (Regulated Activities) 2014.

The service had not received any complaints in relation to the standard of care received and were therefore not aware of the concerns we had raised with them. The manager had initiated sending out surveys to gain relatives feedback and was speaking with them when they visited the home. They told us that they had been speaking with people living at the home to obtain their views, this included a recent resident's meeting, and no concerns had been raised.

Requires improvement

Is the service well-led?

Our findings

People were positive about the manager of the home. Relatives were also positive. One relative told us, "If you go to [manager] with anything, it's sorted straight away." They went on to say, "She's marvellous, keeps everyone on their toes."

The manager was very passionate about their role but told us they had become more frustrated with the lack of time they were able to be out on the floor observing due to several office based tasks. They had been working with the regional manager to find ways to address this. However, due to this, and despite regular meetings and audits in relation to medicines, care plans and health and safety, and monitoring from the regional manager, the issues identified at our inspection had not been identified by the service.

Following a previous complaint and a recent safeguarding allegation, the manager and regional manager had developed plans to address any shortfalls. This included the monitoring and report of people's fluids intake. As a result, the amount people had drunk during a day was tallied and where this was under the assessed amount, it was reported to the GP. The GP told us this system was working well. Concerns about engagement had also been highlighted by the regional manager and the manager had met with the staff team to discuss the importance of missed opportunities. However, we found this remained an issue at the home.

The provider, regional manager and manager had a people first approach, however, this was not instilled in the staff team. Staff were aware of people's needs and received guidance but were not working in accordance with these. However, we noted that there were significant gaps in training and this included the provision of dementia training even though the service provided care for people living with dementia. This meant that governance systems in place were not effective as they had not ensured staff worked in accordance with the visions and values of the management team and had not provided sufficient training for them to carry out their role to an acceptable standard. The manager told us that the recent staff changes had been difficult for the team to adjust and as a result had possibly led to a shift in culture, skills and leadership amongst the staff team as key team members had not been on duty.

As a result, this was a breach of Regulation 17 of Health and Social Care Act (Regulated Activities) 2014.

Following our inspection the manager sent us an action plan detailing how this culture change was to be addressed. This included mentorship by a strong member of staff from within the organisation, training provision and closer monitoring by the management team.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 (RA) Regulations 2014 Person-centred care **The service did not ensure people's individual needs were met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The service did not ensure that people were consistently treated with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The service did not ensure that people were protected from improper treatment or neglect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The systems in place had not identified and therefore had not ensured people received a safe and appropriate standard of service.**