Young@Heart (Bernash) Care Home Ltd

Bernash Care Home

Inspection report

544 - 546 Wells Road, Whitchurch
Bristol, BS14 9BB
Tel: 01275 833670
Website: www.youngatheartch.co.uk

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service responsive?	**Requires improvement**

Overall summary

We carried out a comprehensive inspection of Bernash Care Home in February 2015. We found a breach of the legal requirements at that time. This related to care plans which did not provide clear information about the care a person required. After the inspection, the provider sent us a report of the action they would take to meet the legal requirements.

We undertook a focused inspection on 5 August 2015. This was to check on the actions taken by the provider and to confirm they now met the legal requirements. We also looked at matters arising from information we had received in recent weeks from the service and from the local authority. In particular, this information had raised concerns about how medicines were being managed and the support people received with keeping safe.

This report only covers our findings in relation to these specific areas. You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for 'Bernash Care Home' on our website at www.cqc.org.uk

Bernash Care Home is a care home without nursing that provides personal care for up to 23 older people. The home mainly provides support for older people who are living with dementia. There were 22 people living at Bernash Care Home at the time of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the provider was not meeting the legal requirements in one area. This involved people's

Summary of findings

medicines; these were not being managed in a safe way which protected people. We also found that the staffing arrangements lacked a planned approach to ensure the needs of people living with dementia were well met.

Action had been taken to improve the system of care planning and to comply with the breach made at the last inspection. However, there were aspects which were not well developed. In particular, activities were not personalised and did not fully reflect the needs of people living with dementia.

We found one breach of the regulations during our inspection. You can see what action we told the provider to take at the back of the full version of the 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?

People were not well protected from the risks associated with medicines. Their medicines were not being managed in a safe way.

Sufficient action had not been taken to ensure people received a service that was consistently safe.

Requires improvement

Is the service responsive?

The home's system of care planning had been developed to provide better information about people's needs. However, there were shortcomings in how the plans were being evaluated; it was not clear how well the plans were being implemented and whether any changes were needed.

People were supported by staff to take part in a variety of activities. However, the provision of activities did not show a personalised approach to people living with dementia.

Requires improvement

Bernash Care 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 was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a focused inspection of Bernash Care Home on 5 August 2015. We checked that the improvements planned by the provider after our comprehensive inspection in February 2015 had been made. We also looked at matters arising from information we had received in recent weeks from the service and from the local authority.

We inspected the service against two of the five questions we ask about services: is the service safe and is the service responsive. This was because the breach found at the last inspection, and the information we have since received, were in relation to these questions.

The inspection was unannounced and undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before carrying out the inspection, we reviewed the information we held about the home. This included the report we received from the provider which set out the action they would take to meet legal requirements. We looked at the notifications and any information of concern we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our inspection we spoke with five people who lived at the home and with six relatives. We made observations in order to see how people were supported by staff. We also spoke with five staff members and with a deputy manager (referred to as 'staff' in this report). The registered manager was available throughout the inspection. We looked at four people's care records, together with other records relating to medicines and activities.

Requires improvement

Is the service safe?

Our findings

We had received several notifications from the service prior to this inspection. These referred to incidents which had arisen involving the safety of people at the home. The registered manager had also reported a number of incidents to the local authority in accordance with safeguarding procedures. We were contacted by the local authority in connection with information they had been given about the service.

At our inspection on 5 August 2015, we looked at matters arising from these incidents and the information we had received. This included checking the staffing arrangements and the home's procedures for managing people's medicines.

Medicines in current use were kept securely in a locked trolley. A separate facility was being used for the storage of medicines which were no longer required. A record was maintained which showed that medicines had been returned to the pharmacist.

Staff showed us another cabinet and a drugs refrigerator where stocks of medicines were being kept. We checked their content and identified medicines which staff said were no longer required. However they had not been promptly disposed of. We also found discrepancies between the amount of medicines recorded and the actual quantity being kept. This meant that not all the medicines had been clearly accounted for.

There were other shortcomings in how people's medicines were managed. Some records were not dated and had not been signed by staff. The quantity of medicines recorded had been altered by crossing out and over writing by hand. This meant there was no clear audit of medicines to show the correct quantity on a given day. Records were not being completed consistently. In seven people's records, there were gaps where the administration of medicine, or the reason it had not been given, had not been recorded by staff. This meant it was not clear whether people had received their medication, as prescribed. There were risks to people because of a lack of accurate information about their medicines.

The failure to make suitable arrangements for the proper and safe management of medicines was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that, on each shift, a staff member was designated to support people with their medicines. At the time of our inspection, there were three other staff working and each had been allocated a number of people to provide care to during their shift.

Most people spent their time in the two lounges and we saw that staff were available to meet their needs. The registered manager said people's level of dependency had been assessed and were categorised as high, medium or low. They told us this helped to inform them about how many staff were needed. However, this did not form part of a staffing model for the calculation of staff hours and how staff should be deployed. The use of a staffing model can help to ensure that all relevant factors are taken into account when the required level of staffing is being calculated.

We were given mixed feedback about the staffing arrangements overall. Relatives told us that all the staff were kind, but they were very busy and at times more staff were needed. The relatives mentioned incidents that had arisen which they didn't feel all the staff were well equipped to deal with.

Staff said they felt people were safe but said their support for people was adversely affected if a staff member could not work at short notice and was not replaced. Staff told us they had learnt about dementia care on a one day course but would benefit from further training. This was following incidents involving people at the home who lived with dementia and staff wanting to be more knowledgeable about how the dementia affected people's behaviour.

Staff were aware of risks to people arising from their behaviour. They told us that compatibility between people who lived at the home had been a concern, although this had improved following a change in the home's occupancy. We saw that by using distraction strategies, staff were able to help people who appeared to be anxious or agitated. The care records included some guidance for staff about risks relating to people's behaviour. The guidance set out the nature of the behaviour and the general approach to be taken by staff in response to this. However there was a lack of detail to show that a clear and personalised strategy had been developed. This meant that staff may not provided support to people in a consistent way which ensured their safety.

Requires improvement

Is the service safe?

The registered manager acknowledged that people's behaviour and a lack of compatibility had been a factor in relation to their safety. Following our inspection, the arrangements for maintaining a safe service, such as staffing and assessing risks, were discussed at a meeting held under the local authority's safeguarding procedures. The registered manager is producing an action plan in relation to the matters raised.

Requires improvement

Is the service responsive?

Our findings

When we inspected Bernash Care Home in February 2015 we found that the system of care planning had improved. Care plans had been rewritten or updated so they better reflected people's needs. However we saw examples of where a person's plans had not provided clear information to ensure they received care in a consistent way. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After that inspection, the provider told us about the action they were taking in response to this breach. At our focused inspection on 5 August 2015 we found that action had been taken in order to meet the regulation. For example, further details had been added to the care plans in relation to the person's life history and interests. This meant the plans provided better information to help ensure staff supported people in a person centred way.

Records showed a system was in place for the care plans to be reviewed on a monthly basis. This was a positive development however there were shortcomings in how the plans were being evaluated. The evaluation tended to repeat the identified need, rather than identify whether support had been provided as set out in the care plan. This meant it was not clear how well the plan was being implemented and whether any changes were needed.

One care plan, for example, highlighted the need for the person to wear hearing aids and for this to be checked by staff. The evaluation did not provide information about the outcome of the checks and whether the aids were being worn. In people's plans for social interests and hobbies we read about the activities they enjoyed such as gardening and going out for coffee. The evaluations did not show how well the plans were being implemented and the frequency of these activities.

At different times of day, staff were engaged with people in a variety of activities. We saw activities taking place such as a game of bingo and magnetic darts. Some people listened to music, filled in a 'colouring sheet' and watched television. Although activities were being arranged and staff sought to involve people in these, they did not show a personalised approach to people living with dementia. The activities were not clearly based on people's interests and hobbies as described in their care plans.

We met one person in their room who was very dependant on staff support. Staff had received some guidance about providing stimulation for this person, for example by having the radio on and the use of a ceiling mobile. However it was not clear whether the radio was tuned into an appropriate station for this person and we judged more could be done to create a visually stimulating environment.

Two rummage boxes had been provided since the last inspection. We did not see these being used; one did not contain enough suitable items and appeared to have been used as a waste bin as it contained used tissues and wrappings.

The registered manager acknowledged that more needed to be done to develop activities and an environment that better reflected the needs of people living with dementia. Some work had been started and changes in the décor were being planned. The registered manager told us it was the intention to seek further advice from professionals outside the home who had the relevant experience and knowledge.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered person was not making suitable arrangements for the proper and safe management of medicines.