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Bearnett House

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 8 October 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Regulation 12 HCSA (RA) Regulations 2014 Safe care and treatment. This was relating to the management of medicines and assessing the risks to the health and safety of service users. On 6 November 2015 we issued a warning notice to the provider. We told the provider to take action before the 31 December 2015.

We undertook this focused inspection to check that they had followed their plan and to confirm 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 Bearnett House on our website at www.cqc.org.uk

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.

At the focused inspection on 5 January 2016 we found that some improvements had been made to the way medicines were managed. People's medicines had been reviewed to ensure they received the correct medicines. However when people were prescribed 'as required 'medicines it was unclear when and why they should be given, as there was no guidance for staff in place. We saw that medicines were stored in a safe way. When liquid medicines were prescribed, opening dates were clearly displayed to ensure that they were still safe to use and measures taken to ensure that people received the correct medicines. Staff told us and we saw systems were in place to audit medicines to ensure any errors could be identified and rectified.

Some improvements had been made to the way risks were managed. When people were at risk from harm this

Summary of findings

had been identified and assessed. There were management plans in place however we saw that people's support did not always reflect the way their care was planned.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

We found that action had been taken to improve the safety of medicines but further improvements were required. When people received 'as required' medicines information was needed to ensure that people received it as prescribed. There were process in place to store and record medicines in a safe way.

We found that action had been taken to manage the risk to people but further improvements were required. Care plans had been updated and risks identified, however action was not always taken to reduce this risk. Falls were managed in a safe way.

Requires improvement

Bearnett House

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 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.

We undertook an unannounced focused inspection of Bearnett House on 5 January 2016. This inspection was completed to check that improvements to meet the legal requirements set out in the warning notice had been made. We inspected the service against the safe question. This was because the provider was not meeting some of the legal requiments at the last inspection.

The inspection was carried out by one inspector, a pharmacy 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. We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information we had received from the public.

We spoke with three people who lived there, the registered manager, the care manager and three care staff. We did this to gain people's views about the care and to check that standards of care were being met.

We spent time observing care and support in the communal area. We observed how staff interacted with people who used the service and we looked at the care records for 15 people. We checked that the care they received matched the information in their records. We also looked at records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Bearnett House on 8 October 2015 we found that the management of medicines was not safe. People were not receiving their medicines as prescribed and medicines were not stored safely. There were no safe systems in place to ensure people's needs regarding 'as required' (PRN) medicines were met. We also found that risks to people were not always managed in a safe way.

These were breaches of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. We issued the provider with warning notices to improve the way medicines and risks associated with people's care were managed. We told the provider that improvements must be in place by 31 December 2015.

During this inspection we found that the provider had followed the action plan they had written to meet the shortfalls. However, they had not considered that protocols were needed for as required medicines. We found further improvements were still needed.

For example, when people were prescribed 'as required' medicines we saw there were still no records to confirm why staff were administering these. One person was prescribed medicines for agitation to be given 'as required' records showed us this medicine had been administered. There was no documentation and staff could not confirm the reason why this was administered. This meant we could not be sure people were receiving their medicines as prescribed.

Staff told us and we saw that a system was in place to check that previous medicines had been administered. Staff and the registered manager told us how they checked the medication administration record (MAR) to ensure no gaps were found or errors made. They told us action would be taken if a gap was identified. However we saw that gaps were on the MAR sheet and we did not see evidence that action had been taken. Monthly medicines audit had been introduced, however when concerns were identified action was not always taken. For example, we found that the audit stated that not all medicines had been carried forward from the previous months. We did not see any action taken to rectify this and we saw on the MAR sheet that this continued to occur. We discussed this with the registered manager and care manager who identified this was an area that needed improving. This showed us when needed action was not always taken to make improvements.

This is a continuing breach of Regulation 12(g) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.

Staff told us improvements had been made and medicines were now managed in a safer way. One member of staff told us that, "All the changes were positive". We observed that staff took the MAR which had a photograph on, to the person to administer their medicines. This ensured that the risk of administering the medicine to the wrong person had been reduced.

At our last inspection we found medicines were not always stored securely. One person was administering their own medicines and we found these medicines were not stored in a safe way. We also saw that other medicines were left on the top of the medicines trolley. At this inspection all medicines were stored in a safe way. No one was currently choosing to self-administer their medicines. We saw dates were written on all liquid medicines once they were opened and

this showed us that medicines were within their use by date and safe to administer.

At our last inspection, we found, there were no risk assessments in place to manage behaviours that challenged people's safety. At this inspection we saw that some improvements had been made. We saw that care plans had been updated to identify when people were at risk and what may trigger them to have behaviours that challenged. However information was still needed on how these behaviours could be managed and reduced. For example, one file we looked at had been updated and stated that the person could become 'verbally aggressive towards people and sometimes lashed out'. We did not see any records to confirm how this behaviour may be managed. Staff we spoke with were aware of these behaviours however gave differing views on how they would support the person and protect others. One staff member told us, "We intervene and guide [the person] away". Another member of staff said, "We ensure that people are not together in the first place". This demonstrated that staff did not always work consistently to manage behaviours that challenge.

Requires improvement

Is the service safe?

At this inspection we saw the use of an action plan file had been introduced. When a risk had been identified an action plan sheet was put into place to manage the risk. However we saw actions that had not been completed. For example, one person had an action plan in place stating that a GP needed to be contacted. We saw no evidence that action had been taken on this and the care manager confirmed that the referral had not been made. We also saw one person had sustained an injury but the cause was unknown. We saw and the care manager confirmed that no action had been taken or measures put in place to identify how this had occurred or how the risk could be reduced in the future. This showed us when risks were identified appropriate action was not always taken.

This is a continuing breach of Regulation 12(a) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.

At our last inspection we found risks to individuals were not always managed safely. At this inspection we saw that improvements had been made. We saw that when people were at risk of falling, care plans had been updated. These had measures in place to identify how the risk of falling could be reduced. We saw that referrals had been made to relevant professionals and recommendations that had been suggested had been followed. For example, people had received medical tests to ensure there were no underlying health problems.

Staff we spoke with were aware of how to manage falls. One member of staff told us, “We have been updated about this”. The registered manager told us that a falls protocol had been introduced and we saw this was displayed in the communal area. They told us there was a list attached to it that all staff had to sign once they had read it This demonstrated that staff took accountably and confirmed they understood.

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 People were not safe as medicines were not managed in a safe way.Protocols were not in place for as 'required medicines'. When concerns were identified through audits action was not always taken. When risks to people identified action had not always been taken to reduce these risks.