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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**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was unannounced and took place on 6 December2016. The service was registered to provide accommodation for up to 29 people. At the time of our inspection 19 people were using the service. At the last comprehensive inspection this provider was placed into special measures by CQC. The overall rating for this service is 'Requires improvement' and the service remains in special measures. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

After the comprehensive inspection in May 2016 we took enforcement action by restricting admissions to the service and introducing positive conditions around the management of falls.

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.

Risks to people were not always managed in a safe way. When incidents had occurred the provider had not always completed risk assessment to reduce the risk of this reoccurring. When people were at risk of falling people were not always supported in line with recommendations made. Risks assessments were not always reviewed in line with the provider's procedure. The systems the provider had put in place to keep people

safe were not always followed.

When capacity assessment had been completed it was unclear how decisions had been made. Staff were unsure when people were being restricted and offered an inconsistent approach. When applications had been made about restrictive practices there was no guidance in place to ensure people were supported in the least restricted way.

Complaints were not always responded to in line with the provider's policy. Care plans were reviewed however people felt they were not always involved with this. Health professionals felt that the home lacked leadership. When employment checks had been completed the provider had not assured staffs suitability to work within the home. People's files were stored insecurely. Some of the audits that were introduced were not always effective in identifying concerns.

We have lack of confidence in the actions the providers are telling us they are making in relation to the management of the home and to ensure compliance with the regulations.

Staff were able to recognise and report potential abuse. There were enough staff available and they received an induction and training that helped them to support people. People received their medicines in a safe way and they were stored and recorded to ensure people were protected from the risk associated to them.

When needed people had access to healthcare professionals. People felt they were supported in a kind and caring way by staff they were happy with. People were offered choice and their privacy and dignity was upheld.

People enjoyed the food and were offered a choice; they were able to participate in activities they enjoyed. There were daily arrangements in place to keep staff informed of people's needs. Quality monitoring was completed and this information was used to make changes. Staff felt supported and were given the opportunity to raise concerns.

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 this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.
Risks to people were not always managed in a safe way. There were enough staff available to support people. Medicines were stored and administered to keep people safe from the risks associated to these. Staff understood safeguarding procedures and how to protect people from potential abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.
The principles of the Mental Capacity Act 2005 were not always followed. When people had restrictions placed upon them staff did not always supported people with a consistent approach. Staff received an induction and training that helped them to support people. People enjoyed the food and were offered a choice. People had access to health professionals when needed.

Is the service caring?

Good

The service was caring.
People were supported in a kind and caring way by staff they were happy with. People were offered choice about how to spend their day and their privacy and dignity was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.
Complains had not always been responded to in line with their policy. Care plans were reviewed however some people were not always involved with this. People had the opportunity to participate in activities they enjoyed and received care in their preferred way.

Is the service well-led?

Inadequate

The service was not well led
Concerns have been identified about the provider and whether they can sustain the improvements they have been making. The providers remains in breach of regulations and has not made the necessary improvements needed to comply. There are concerns with the management of the home and the lack of leadership. Not all of the audits introduced were effective in highlighting

concerns. Records were not kept securely and the recruitment procedures in place did not always ensure staff were safe to care for people. Staff felt supported and listened to.

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.

This inspection visit took place on the 6 December 2016 and was unannounced. The inspection visit was carried out by two inspectors and a specialist advisor who had experience of management of falls. 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 also spoke with the local authority that had provided us with current monitoring information. We used this to formulate our inspection plan.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spent time observing care and support in the communal area. We observed how staff interacted with people who used the service. We spoke with three people who used the service, two relatives, four members of care staff, two senior care staff and the maintenance person. We also spoke with the registered manager and two providers. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at the care records for eight 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, including quality checks and staff files.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection on 3 May 2016, we found risks to people were not managed in a safe way and we could not be sure people were protected from potential abuse as safeguarding concerns were not always investigated or reported. We found there were insufficient staff to keep people safe and safe systems were not in place in relation to the management of occasional medicines. We carried out a focused inspection on 27 July 2016 due to information of concern we had received and we found improvements had not been made. This was a continued breach of Regulation 12 (2) (a) of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.

At this inspection we found some improvements had been made however further improvements were needed. Risks to people were not always managed in a safe way. Before the inspection we had received some information about an incident that had occurred within the home. Although the provider had recorded the incident and reported it to the local authority safeguarding team a risk assessment had not been completed to minimise the risk of this incident happening again. We spoke with one of the people involved with the incident and they told us, "It shook me up I was scared at the time". They went on to tell us they had not been updated since they had reported the incident and did not know what action the provider had taken. We also heard during the staff handover that an incident had occurred during the night between two other people. A staff member confirmed that no incident form had been completed and no action had been taken to manage the risk. This meant when incidents occurred we could not be sure action was taken to reduce the risk.

When people were at risk of falling we saw risk assessments had been completed and reviewed however this was not always in line with the provider's procedure. For example, we looked at the provider's procedure which stated that when a person had fallen the risk assessment and care plan for this person, should be reviewed and updated. We saw when people had fallen this had not always been updated. For example, we looked at records for one person who had fallen, their care plan and risk assessment had not been reviewed until three days after the fall had occurred. We saw for three other people risk assessments had not been reviewed after falls had occurred. This meant we could not be sure action had been taken in line with the provider's procedure to reduce the risks of further falls.

When people were at risk of falling we did not always see they were supported in line with their care plans and risk assessments. For example, we observed that one person was at risk of falls. We looked at records for this person; these stated that if this person was walking independently around the home then staff should 'always encourage me to continue to mobilise'. It was also stated, 'staff should always guide me around where I chose to go'. It was documented that the falls prevention team had recommended, 'staff need to encourage me to raise my head when walking to prevent me from bumping into things'. We observed that staff did not always follow these recommendations. When the person stood up to mobilise we observed that staff would often guide the person back down to their seat, or staff would guide the person to a different seat. We spoke with a staff member who confirmed they did not know how to support this person when mobilising. We did not see that staff encouraged the person to raise their head. This meant we could not be sure people were supported in line with recommendations.

We were told by the registered manager that the communal lounge must be supervised by staff at all times during the day to ensure people were safe. We observed for a period of 25 minutes during the morning of the inspection that the communal lounge was not supervised by staff. During this time seven people were present in the lounge. Two of these people had been assessed as at risk of falls. We observed that both of these people tried to stand independently during this time, however as tables had been placed in front of them they were unable to do so. One of the people tried to remove the table which was causing a hazard for them, we observed this person stumbled and then sat back on their chair.

This is a continuing breach of Regulation 12 (2) (a) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

We saw improvements had been made in relation to staffing levels since our last inspection. One person said, "I don't press my buzzer very often but when I do the staff come, it's much quicker than before". Staff confirmed there were enough staff available. One staff member said, "Since the amount of residents has reduced it's been much better". Another member of staff told us, "There are enough staff to deal with situations now". We saw people did not have to wait for support. We spoke with the registered manager they said, "We have learnt about staffing, when people come into the home in the future it is important that we review staffing levels to ensure there are enough staff".

Staff knew how to recognise and report potential abuse. One member of staff told us, "I have a duty to report any risks or suspected abuse". Another staff member said, "I would report it to the manager and take it further if needed". Staff told us and we saw that people had completed safeguarding training since our last inspection. We saw there were procedures in place advising staff what actions to take if they had concerns. We saw that when needed concerns had been raised by the provider and in line with these procedures to ensure people were protected from potential harm.

People were happy with how they received their medicines. One person said, "I have had my tablets, they ask me if I need extras if I am in pain". We saw staff administering medicines to people in a safe way. Staff spent time with people ensuring they had taken them. We saw that when people were prescribed medicines on 'as required basis', there was guidance in place for staff to show when these should be given and this was offered to them. We saw there were effective systems in place to store, administer and record medicines to ensure people were protected from the risks associated to them.

Requires Improvement

Is the service effective?

Our findings

At our comprehensive inspection on 3 May 2016, we found people's rights under Mental Capacity Act 2005 (MCA) were not addressed. At this inspection we found the required improvements had not been made.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so or themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked to see if the provider was working within the principles of MCA. We saw when needed mental capacity assessments had been completed. However, for some people it was unclear how decisions regarding their capacity had been made. In the records we looked at we saw it was recorded that the lack of capacity was due to 'their dementia' or 'they would not be able to make or understand any relevant information long enough to make any kind of decision'. This meant because all the assessments were the same we could not be sure people's capacity had been fully considered.

When people had DoLS authorisation in place staff were unsure who these people were and what this meant. One staff member told us, "I know what it is and what it consists of, but we don't deal with that here". Another staff member said, "I don't know who is on a DoLS". We saw and the registered manager confirmed two people had DoLS approvals in place by the local authority. This meant we could not be sure these people were supported in line with their DoLS authorisations. When applications had been made for restrictions there were no records in place identifying how staff supported people in the least restrictive way whilst these applications were considered. We saw a further eleven applications had been made and we observed during the inspection that three people were trying to leave the building or requesting to. We observed that staff responded to people in different ways. For example, one staff member told one person they would take them out for a walk, however we did not see this happen. Another staff member verbally told the same person they were not going home. This meant staff did not offer a consistent approach because there was no information to support the staff on how to manage these situations.

This is a continuing breach of Regulation 11 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Staff received an induction and training, one staff member who had recently started working within the home told us about their induction they said, "I did lots of training which was useful and informative. On my first day it was face to face and I had to read everyone's care plans so I was familiar with people. I then shadowed a senior member of staff. I found that was very helpful". This showed us that staff shared knowledge they had to offer care and support. Another staff member told us about their training. They said, "It's a lot better now, we have it in areas we need like the diabetic training". In the PIR the providers told us

they had introduced an induction programme for new starters; they were also using an external training company to deliver training for staff. We saw this had been completed.

People told us they enjoyed the food and were offered a choice. One person said, "It looks lovely and it smells lovely". We saw there were cold drinks available in the communal areas for people. And hot drinks and snacks were offered in the communal areas throughout the day. We saw that when people needed specialist diets such as a soft diet this was provided for them in line with their care plan.

We saw when needed people had access to healthcare professionals. For example, we saw referrals had been made to a range of professionals including speech and language therapists and specialist nurses. One person said, "The nurse has been this morning, I'm having a few tests. The staff help me keep on top of things and make sure I'm well". This meant people had access to health professional when needed.

Good

Is the service caring?

Our findings

At our comprehensive inspection on 3 May 2016 people were not always supported in a dignified way. At this inspection we found improvements had been made. One person said, "The staff ask me more now and spend more time with me, which is better. They don't rush me". The atmosphere appeared friendly and relaxed. We observed staff supported people in a kind and caring way. Staff spoke to people using their preferred names and offered support to people when needed. For example, at lunch time we observed a staff member offer support to a person as they were struggling. They accepted and the staff member supported them. When people were leaving their rooms to join the communal areas staff offered support with their appearance. One staff member said, "Shall we brush your hair before we go down stairs". To which the person agreed. People and relatives we spoke with told us they were happy with the staff. One person said, "There a lovely bunch". A relative told us, "They lost a lot of staff and have had quite a few new ones, they are all good. The new ones are getting along really well".

People were able to make choices about how to spend their day. One person said, "I like my breakfast in my bedroom and then later at lunch I go out in the communal lounge. All day is too much I like some quiet in a morning". We observed staff ask people where they would like to sit and what they would like to watch on the television.

People told us their privacy was promoted. One person said, "They always knock my door and I shout come in. Because of that big window they make sure the curtains are closed when they are in here with me". Staff gave examples how they promoted people's privacy. One person said, "We knock doors and when people are using the bathroom give them so privacy".

Relatives and visitors we spoke with told us the staff were welcoming and they could visit anytime. One person said, "I have lots of visitors my relations are coming later, they come different times and the staff let me know when they are here which is nice". A visitor told us, "I can come anytime". They went on to say, "The staff are always welcoming". We spoke with a senior member of staff who told us visitors and relatives could visit anytime.

Requires Improvement

Is the service responsive?

Our findings

At our comprehensive inspection on 3 May 2016 we could not be sure all complaints had been responded to. At this inspection we found further improvements were needed. Before the inspection we had received information that a complaint had been made to the registered manager and no action had been taken. We saw this complaint had been logged and had now been actioned. However, the registered manager had not responded to the complaint in line with their procedure. We spoke with the registered manager who told us they had verbally responded to the complaint, and they confirmed they should have provided a written response and acted earlier.

This is a breach of Regulation 16 (2) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

We saw care plans had been reviewed however some people were not always involved with this. One person said, "It would be nice to be asked more, it may be that's something they could do in the future". We looked at records for people, care plans and risk assessments were reviewed monthly to ensure information was updated when needed. We spoke with a member of the senior care staff. They said, "We are looking at being more person centred and that's something we need to work on next".

People told us they enjoyed the activities in the home. One person said, "There was a lot going on but now the activity coordinator has left, the other staff do some things with us but not as much". The registered manger told us the activity coordinator had recently left and the position was being advertised. We saw staff interacting with people and we observed an exercise session taking place. One person said, "I like the balloon". This meant people had the opportunity to participate in activities they enjoyed.

Staff knew people likes and dislikes. One person said, "I think they know me by now. They know I have my breakfast before my wash and they know when I like a bath". The provider had introduced a 'my life story' this had information about people's likes dislikes and preferences. We saw these had been completed for some people and others were being considered.

Inadequate

Is the service well-led?

Our findings

At our comprehensive inspection on 3 May 2016, the providers did not have suitable systems in place to ensure areas for improvement were identified. At this inspection we found further improvements were needed. Before the inspection we spoke with a range of health professionals who work closely with the service. The feedback we had from these professionals was although the home was making some improvements they were unsure if they could sustain these. One health professional told us, "They have improved, it's more organised and the paperwork is much better. However, I would be concerned if lots of people were admitted to the home at once". Another health professional said, "Its leadership, the home lacks good leadership". Since the inspection we have received information from a health professional regarding their concerns with the registered manager. These concerns were in relation to their lack of understanding around confidentiality. For example, how they spoke about another person in front of other people and the staff.

Since our first comprehensive inspection on 8 October 2015 the provider has continued to be in breach of Regulation 11, 12 and 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. We have inspected this location on five separate occasions in a fourteen month timeframe. Despite two meeting with the providers and four action plans we have found that the provider has not made the necessary improvements to comply with these regulations. We have continued to identify concerns with the management of the home. We reviewed the action plan that was sent to us on 2 September 2016 they told us, 'Plans have been agreed by the providers to replace the current home manager to enable responsibilities and requirements from the CQC to be met.' They told us this would be completed by 1 November 2016. We found this had not happened and therefore we cannot be assured the providers are addressing our concerns with the management of the home.

In the action plan of 2 September 2016, the providers also gave us assurances they understood and could meet the legal requirements under the mental capacity act. The action plan stated, 'Care plans have been revamped to include a 'MCA' section. Copies of MCA assessments have been completed and filed within this section'. We saw this action had been marked as completed. At the inspection although we found mental capacity assessments were in place, they were not individual and people's capacity had not been fully considered. Therefore we could not be assured the providers understood the requirements of the regulation to ensure they were compliant.

Before the inspection we had received a notification from the service, we reviewed the information recorded in the notification at the inspection. The notification alleged an unwitnessed assault on one person by another. The notification stated they did not initially report the incident. It was only when the person showed staff alleged bruises from the incident three days later that action was taken and the incident reported to us and safeguarding. Therefore we could not be sure the provider was responsive to concerns raised or shared these appropriately.

We could not be sure people received consistent care to support their sore skin. When people needed their position to be monitored we saw positioning charts were in place. It was unclear from people's care plans

and risk assessments how people needed support with this. For example, we saw recorded that people should be 'turned regularly'. We spoke with staff who told us inconsistent information. One staff member said, "At one, three and six during the night so I guess its two hourly". Whereas another staff member said, "Just throughout the day, when they are uncomfortable". On the positioning charts we looked at for both people we saw when people were out of bed these were not completed. The positioning chart also stated that the position of the person should be documented. We saw this had not been completed. The care plan audit that had been introduced had not highlighted this lack of information. This meant the audit was ineffective in highlighting any areas of improvement.

We found that people's records were not kept securely. Care plans were stored in the office. We saw the door to the office was unlocked throughout the day which meant that people's personal information was at risk of being breached or damaged by unauthorised access.

At the comprehensive inspection on 3 May 2016 we highlighted concerns with the provider's recruitment process. At this inspection we found that when information had been received by the provider about staffs lack of suitability to work within the home they had not completed the necessary risk assessments. No action had been taken to ensure people who used the service were suitably supported. We also found for some staff that references had not been obtained. This meant we could not be sure the provider had a suitable recruitment process in place to ensure people were safe.

This is a continuing breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

The provider had introduced a range of audits since our last inspection. We saw that a medicine, home and quality audit had been introduced. Since the initial audit in August 2016 we saw the score had increased from 75% to 95%. We looked at the medicines audit and we saw when needed action had been taken. For example we saw a medicines error had been identified through the audit. In the action plan folder we saw that the providers had met with the staff member and set an action plan to ensure this did not reoccur. This meant when needed the provider had taken action.

Staff told us and the management team confirmed that supervisions and team meetings were taking place. One member of staff said, "We had a team meeting yesterday and I had a supervision two weeks ago". Another staff member said, "The seniors are good, [staff] has really made a difference since they have been here. We are more organised and everything is so much better". They went on to say, "Morale has been low but I think now the providers are more involved there is much better support. We seem to know what we are all doing now".

We saw that the rating from the last inspection was displayed around the home in line with our requirements. The provider understood their responsibilities around registration with us and had notified us of significant events that had occurred at the service. This meant we could check if the provider had taken the necessary action.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent As all mental capacity assessments were the same, we could not be sure people's capacity had been fully considered. When people had DoLS authorisation in place staff were unsure who these people were and what this meant.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not managed in a safe way. When incidents had occurred we could not be sure action was taken to reduce the risk. When people were at risk of falling, risks assessments were not always reviewed after a fall had occurred. People were not always supported in line with recommendation around falls.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints We could not be sure all complaints had been responded to in line with the providers policy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We cannot be assured the providers are addressing our concerns with the management

of the home and providers understood the requirements of the regulation to ensure they were compliant. Some audits were ineffective in highlighting areas of improvement. records were not kept securely. We could not be sure the provider had a suitable recruitment process in place to ensure people were safe.