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Bearnett House

Inspection report

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Ratings

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

Overall summary

The inspection took place on 8 October 2015 and was unannounced. Bearnett house is registered to offer accommodation with personal care to 29 older people who have a physical disability and or for people living with dementia. There were 24 people living in the home and two people receiving respite services on the day of the 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.

Although people felt safe and relatives did not raise any concerns, some people's safety was compromised. Some staff had not had the training needed to support people safely. Staffs limited knowledge around safeguarding meant that people were potentially placed at risk. The provider did not always report or investigate safeguarding concerns as required. Risks associated with people's care

Summary of findings

such as falls prevention were not always managed appropriately. When there were risks we found that risk assessments were not in place and no action was taken to reduce the risk.

People's medicines were not managed, stored or administered in a safe way. There was no guidance in place to ensure staff understood when to give people 'as and when' required medicines. Referrals and reviews to health professionals were not always made when needed. We found that some people had to wait to receive the healthcare they required because equipment was not always available.

The Mental Capacity Act 2005 was not always followed to ensure important decisions about people's care were made. Mental capacity and best interest assessments were not completed to identify decisions were made in people's best interest. The provider had not considered that some people may be being restricted and that deprivation of liberty safeguard referrals may be required.

People's privacy and dignity was not always protected. The handover and the communication booked containing personal details about people were stored in the communal area and could be freely accessed. We found the environment did not offer any stimulation or support for people living with dementia. People did not have the opportunities to participate in activities they liked which meant some people's social needs were not being met.

There was no information or system In place for staff to raise anonymous concerns. The provider did not have a whistleblowing policy in place. Quality monitoring systems were not effective in making improvements to the service. Safe recruitment practices were not always followed to ensure the suitability of people working in the service. The provider was not meeting their legal responsibility in notifying us about significant events.

People were provided with food and drink which they enjoyed. People were offered choices at mealtimes and we saw they were offered drinks throughout the day. We saw that staff interactions with people were kind and staff knew people well. We found there were enough staff available for people. Visitors told us they could visit at any time and the manager was available.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and The Care Quality Commissions (Registration) Regulation 2009. 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?
The service was not safe.

People were not safe as medicines were not managed, stored or administered in a safe way. When people were at risk no management plan were in place to manage identified risks. The provider did not take reasonable steps to report and investigate potential abuse.

Inadequate

Is the service effective?
The service was not consistently effective.

The Mental Capacity Act 2005 was not used to demonstrate decisions were made in people's best interests, when people lacked capacity. Some staff did not have the knowledge and skills to ensure people's needs were met. People did not always have access to other healthcare services in a timely manner. People enjoyed the food and were offered a choice.

Requires improvement

Is the service caring?
The service was not consistently caring.

People were not always supported to maintain their privacy and dignity. People were happy with the care they received. Relatives were made to feel welcome and were kept informed about their relative's care.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People were not always offered the opportunity to participate in activities of their choice. People and relatives were not always involved with planning and reviewing their care and the service did not always ensure that individual needs were regularly assessed, recorded and reviewed. People knew how to and were able to raise concerns

Requires improvement

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

The provider had not fulfilled their legal responsibility about notifying us of significant events at the service. The systems in place were not always effective in ensuring areas for improvements were identified. People and relatives knew who the manager was but there were no systems in place to drive improvement.

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.

This inspection took place on 8 October 2015 and was unannounced. The inspection was carried out by two inspectors. We looked at information we held about this service and we identified that we were not receiving all the notifications we required from them. A notification is information about important events which the service is required to send us by law. We also looked at the quality monitoring audit which had been completed by the local authority on 25 March 2015.

On this occasion we did not ask the provider to send us 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. However, we offered the provider the opportunity to share information they felt relevant with us.

We spoke with seven people who used the service, four members of staff, the registered manager and four relatives. We also spoke with two health professionals.

Some of the people living at the home were unable to speak with us about the care they received. We observed care in the communal lounge and dining room to understand people's experiences. We looked at five people's care files and observed the way people were cared for, including whether the care people received matched the care which was documented in their files. We looked at staff recruitment files and records relating to quality monitoring systems that were in place.

Inadequate

Is the service safe?

Our findings

We saw one person administered their own medicines. There were no risk assessments in place to show if they were being managed in a way to keep the person and other people safe. Staff confirmed these medicines were not stored securely in the person's bedroom. We saw other medicines were not stored securely and were left on the top of the medicine trolley. This meant people could access these medicines freely placing them at risk of harm.

We saw one person's medicines were prescribed on an 'as required basis' (PRN), and on the medication administration record (MAR) they were being administered on a regular basis. Staff confirmed they had not contacted the person's GP to review this medicine. There were no records to confirm why staff were not administering this medicine as prescribed. By administering medicines on a regular basis there was a risk that this person received these medicines when they did not require them. Another person was prescribed medicines that were for agitation, it was unclear if this was a PRN medicine or a regular medicine, and when we asked, the staff could not confirm this. We saw this medicine had been reduced. Staff told us this was because the person was not agitated that day; they confirmed they had not received advice from the person's GP before reducing this. This meant the person was not receiving their medicines as prescribed by a medical professional. By reducing the medicines without advice there was a risk the person could have become agitated, causing harm to themselves or others. Protocols were not in place to guide staff as to when PRN should be administered. A protocol provides staff administering PRN with information to ensure the medicine is administered safely and when required. It was unclear if some medicines were prescribed as regular medicines or PRN. This meant that safe systems were not in place to ensure people's needs regarding PRN medicines were being met.

We saw liquid medication that had been opened was not dated as required. When we spoke with the staff they were unable to confirm if it was within date. This meant the provider could not be sure if the medicine was within its use by date and therefore safe to administer.

We observed two staff members administered medicines. One staff member dispensed the medicines and the other staff member took the medicines to the person and administered. The staff member dispensing the medicine would then sign for the medicine, even though they had not seen it being taken. This practice is known as secondary dispensing and is considered to be unsafe as it increases the risk of medicines being given to the wrong person.

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

Risks to individuals were not always managed safely. For example we saw one person had fallen five times over a 10 day period. There were no risk assessments in place or information on falls prevention for this person. We did not see that any action had been recorded or taken on how this risk was to be managed or reduced. This meant the person was still at risk of further falls and causing harm to themselves. We were also told by staff there were risks if two people were seated together. We saw these two people were seated together and staff had to intervene to prevent a physical altercation occurring. There were no risk assessments or documentation in people's care plans to explain or highlight this risk.

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

The staffs' understanding of safeguarding people was inconsistent. Staff told us they had received the safeguarding training but could not demonstrate their knowledge and what they had learnt. For example, one person told us, "Unexplained bruising was not safeguarding unless it was severe". Another person said, "It was telling the manger if someone was unwell". This meant that people were at risk of harm as staff had limited knowledge in identifying potential abuse.

We saw documentation that two people had received injuries that could not be explained. Staff and the records confirmed the injuries had been unexplained and had not been investigated. Staff had recorded the injuries on an action plan but had not investigated them. The provider had not reported the injuries to the local authority safeguarding team as required This meant that people were at risk as the provider had not taken reasonable steps to report and investigate potential abuse.

This is a breach of regulation 13 (2) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

The two staff files we looked at did not have all of the required documentation in place to demonstrate that safe recruitment practices were followed. One person had no evidence on file to show that a Disclosure and Barring Service (DBS) check had been received. The DBS is the national agency that keeps records of criminal convictions. The manager confirmed they had not seen the DBS. We checked it had been applied for and found that it had, but the registered manager had not ensured the member of staffs suitability. We saw the provider's application form did not ask staff to declare if they had criminal convictions and we saw another member of staff had no identification kept on their file.

People who used the service told us they felt safe. One person said, "I would never come to any harm here, I can sleep well at night knowing that" People told us there were enough staff and they did not have to wait. One person told us, "I have a buzzer and they come quickly". Another person said, "There is always someone around". People and relatives did not raise any concerns regarding the number of staff available to them. Staff we spoke with told us they were covering shortfalls. One member of staff told us, "They worried they weren't doing things properly." We saw staff were available in communal areas and people did not have to wait. This demonstrated there were enough staff to meet people's needs.

We saw that equipment was maintained and tested. For example the moving and handling equipment was checked and we saw that portable appliance testing had been completed. This demonstrated the equipment was maintained so that it was safe to use.

Requires improvement

Is the service effective?

Our findings

We looked at how the provider was meeting the legal requirements set out in The Mental Capacity Act 2005. When people are unable to make decisions for themselves there are requirements that decisions are made in people's best interests. Staff confirmed that some people who used the service may lack the capacity to make certain decisions, although they had not considered this. Staff we spoke with had not undertaken training on the Mental Capacity Act 2005 and did not demonstrate an understanding of the process to follow when people lacked capacity. We spoke with the manager about this who confirmed when required, mental capacity assessments had not been completed. This meant that people's rights under the Mental Capacity Act 2005 were not addressed. Care files we looked at did not show how people were supported to make decisions. Where people were unable to consent mental capacity assessments and best interest decisions had not been completed.

This is a breach of regulation 11 (3) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

The provider had not considered if any of the people who used the service were at risk of Deprivation of Liberty Safeguards (DoLS). DoLS is when a person, who lacks capacity, may be restricted. We saw no evidence any applications had been made to the local authority. We observed a person approach the door with their coat on. A staff member went with the person and redirected them back into the building. The provider had not considered they may be restricting this person. This demonstrated that staff had not considered if people were being restricted unlawfully.

We saw and staff confirmed that domestic staff were deployed as care staff when there were not enough care staff available. Staff we spoke with and records confirmed that domestic staff had not received training. For example domestic staff had received moving and handling training that was related to objects and not people. Staff confirmed they had not had training in the use of moving and handling equipment. Staff told us they were unsure if they had received an induction. One member of staff said, "I'm not sure if I did, I don't think so". This demonstrated that people were not always supported by suitably trained staff. One member of staff told us, "That training was up in the air". Three members of staff we saw administering medicines confirmed they were not up to date with this training. We did not see any evidence to confirm the provider had any up-to-date plans to develop staff knowledge and skill.

Referrals were not always made to the relevant professionals when needed. We observed that one person was on a pureed diet. Staff we spoke with told us it was because the person was at risk of choking. This person had not been referred to the appropriate professional to support them with their diet. A visiting health professional told us the manager was not always proactive in seeking advice. For example the health professional said the home would wait for them to visit instead of referring their concerns. They said previously they had to, "Ask them to call the GP as someone was unwell". They told us equipment they needed was not always available when they required. For example when they came to change dressing for people, new dressings were not always available. This demonstrated that people did not always receive access to healthcare in a timely manner.

People we spoke with told us they enjoyed the food and were offered a choice. One person told us, "We always get a choice, there's plenty to drink too". Another person said, "It's very good". We heard staff asking people what they would like. There was a meal planner displayed in the communal area showing a choice of two meals for that day. We saw that one person said they did not like the meal they were provided with they were offered an alternate meal by staff.

Requires improvement

Is the service caring?

Our findings

We saw a member of staff offering assistance to a person. This member of staff had to leave this person to support another person who also needed assistance. We observed the member of staff leave the person for 4 minutes. This meant the person had to wait until they could continue with their task. The member of staff did not explain to the person where they were going. Staff told us, "Sometimes we get distracted and have to do other things". We saw the person had to wait for the staff to return before being able to continue with their task. This demonstrated that some people did not receive the individual support they required.

We saw the handover and the communication booked were stored in the communal area and could be freely accessed. These books had personal details in relating to people. This meant that people's privacy and dignity was not always protected.

People told us their privacy and dignity was promoted. One person said, "If I'm unwell, they keep it quiet". Another person told us, "The staff are polite they always knock my door and wait for me to ask them to come in". Staff gave us examples of how they promoted people's privacy and dignity. One staff member told us, "We make sure things are confidential, it's on a need to know basis". Staff confirmed that in the shared rooms screens were used and we saw these were available.

People we spoke with told us they were happy with the staff. One person told us, "The staff are very good, kind and helpful'. Another said, "They are very good, they do above what they are supposed to for me". We saw people looked relaxed with staff and the staff stopped to talk with people and engaged with them. Staff used information they had about people to provide good interactions. For example, we saw a staff member talking to one person about their previous occupation. We saw the person smiling in acknowledgment to this. The relatives we spoke with told us the staff made them feel welcome. A relative told us, "They all know my name; they are friendly and always greet me". We saw staff interacted well with people and their relatives. For example, one relative asked advice from a member of staff. The staff spent time with the relative talking and providing a clear explanation. Relatives and friends told us they could visit anytime.

People told us they were able to make day to day decisions about how they wanted to spend their day. One person told us, "I get up when I want". Another said, "I chose what I want to do, I can do what I like". Some people told us they wanted to spend time in their rooms and we saw that staff respected people's wishes and supported them to spend the day where they preferred.

Requires improvement

Is the service responsive?

Our findings

One person told us, “There just aren’t any activities going on at all”. Another said, “I would like to do some crafts, but there isn’t the opportunity”. Staff confirmed activities were not taking place and that people lacked stimulation. A staff member told us, “People need stimulation; there is no time for us to do that” We did not see any activities taking place. The majority of people remained sitting in the lounge or communal areas. The environment did not offer any objects to support people living with dementia. The manager identified this was an area that required improvement. They told us they were in the process of recruiting an activity co coordinator.

Some people told us they were not involved with planning or reviewing their care. One person said, “I leave all that to the staff, I didn’t know I could.” Another person told us, “I would like to me more involved with it”. A relative told us they had not been informed about changes that had been made to their relatives care. The care files we looked at did not show how people had been involved in the planning or management of their care and support.

People told us staff knew about their needs and preferences and provided support in a way they wanted it. One person said, “They all know me, they know how I like things done”. Another person explained how the staff knew their morning routine and they would follow it each morning. We saw that staff knew people well. For example, at lunchtime we saw a member of staff go and get the salt for a person before they asked for it. We heard the staff member say they had forgotten to put it ready for them.

People and their visitors told us if they had any concerns or complaints they would feel happy to raise them. People we spoke with were happy with the home and the care they received and did not raise any concerns or complaints. The provider had a complaints policy in place that was displayed in the hall and they had a system in place to manage complaints.

Requires improvement

Is the service well-led?

Our findings

The provider's legal responsibilities had not been met regarding statutory notifications that are required in accordance with the regulations. The provider is required by law to notify us of any significant events that occur at the service. We identified that the provider had not notified us about safeguarding investigations that were being undertaken by the local authority. This meant that the registered person had not notified us, as required about any abuse or allegation of abuse in relation to a person using the service.

This is a breach of Regulation 18 (4) (B) of the Care Quality Commission (Registration) Regulations 2009

There were some systems in place to monitor the quality of the service. However, we did not see the information had been used to bring about changes. For example we saw medication audits had taken place; however no action plan had been made following the audit. The audit had been completed on a monthly basis over a six month period identifying the same areas of improvement were needed. This demonstrated that when changes were required no action was taken to improve.

Systems that were in place to review and monitor care were not always effective. We saw care files were reviewed monthly; however there was no evidence that changes to people's care had been made through these reviews. For example, one person had damaged skin. We saw documentation had been put in place when this had occurred. The person's care plan had been reviewed but no action had been taken to prevent this happening again. We saw checks were in place to monitor the temperature that medicines were stored at. We saw these checks were not always complete. There was a chart and a thermometer to check the temperature; however the chart had not been completed.

The manager told us that satisfaction surveys were completed and the findings were used to bring about improvements. We saw surveys had been completed by friends and relatives of people who used the service but we did not see any evidence this information had been shared with people or used to demonstrate if and where improvements had been made.

Staff we spoke with told us they would raise concerns with the manager if they were worried about anything but did not know if there was a whistleblowing policy in place. A whistleblower is a member of staff who raises concerns about how the service is run. The manager was not able to provide us with a copy of the policy.

People and relatives told us the manager was available and knew who she was. One person said, "She comes up and sees me each day". A relative told us, "She is around every day, everyone knows who she is". Staff told us and the manager confirmed that supervisions and staff meeting were not taking place. This meant that staff did not have the opportunity to share their views and be actively involved with the development of the service.

This is a breach of regulation 17 (1) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

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 11 HSCA (RA) Regulations 2014 Need for consent The Mental Capacity Act 2005 was not used to demonstrate decisions were made in people's best interests, when people lacked capacity.

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, stored or administered in a safe way. When people were at risk no management plan were in place to manage identified risks

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 provider did not take reasonable steps to report and investigate potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems in place were not always effective in ensuring areas for improvements were identified.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents We identified that the provider had not notified us about safeguarding investigations that were being undertaken by the local authority.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

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, stored or administered in a safe way. When people were at risk no management plan were in place to manage identified risks.

The enforcement action we took:
Warning notice.