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Bearnett House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We undertook this focused inspection on 27 July 2016 as we had received further information of concern around staffing levels within the home. We also received information of concern of how risks to people were being managed. At our comprehensive inspection of Bearnett House on 4 May 2016, we found there were not always enough staff to keep people safe. We also found that risks to people were not managed in a safe way. These were breaches of regulation 12 and 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. The service was overall rated as inadequate and was placed into special measures. In addition a notice of decision to restrict admissions into the home was issued as well as a notice of proposal with positive conditions around the management of falls within the home.

This report covers our findings in relation to the information of concern we received. It also covers related information gathered as part of this inspection visit. You can read the report from our last comprehensive inspection visit, by selecting the 'all reports' link for the Bearnett House on our website at www.cqc.org.uk.

The service is registered to provide accommodation for up to 25 people. At the time of the inspection 22 people were using the service.

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.

People continued not to be safe. Risks to people's care such as falls were not managed appropriately. When incidents had occurred the provider had not taken action to reduce the risk of the incident reoccurring. Systems that had been implemented to mitigate errors were not effective. There were not sufficient staff as recommended by the provider to support people's needs. The provider had breached the registration condition we had recently imposed.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
There were not enough staff as identified by the provider and risks to people were continually not managed in a safe way. The provider had breached the registration condition we had recently imposed.

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 27 July 2016 and was an unannounced focused inspection. We carried out this inspection as we had received further information of concern around staffing levels within the home. We also received information of concern of how risks to people were being managed. The inspection visit was carried out by two inspectors. We inspected the service against one of the five questions we ask about the service which is, is the service safe?

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 and other health care professionals. We also spoke with the local authority that provided us with current monitoring information. We used this to formulate our inspection plan.

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 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 care staff, a domestic member of staff and a visiting health professional. We also spoke with the manager of care, the deputy manager, the registered manager and a representative for the 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 four 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 rotas.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection of Bearnett House on 4 May 2016, we found there were not always enough staff to keep people safe. We also found that risks to people were not managed in a safe way. These were breaches of regulation 12 and 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. The service was overall rated as inadequate and has been placed into special measures. In addition we have restricted admissions into the home and agreed regular reporting arrangements in relation to the management of falls within the home.

In addition to our findings at the comprehensive inspection in May 2016, we found at the focused inspection on 27 July 2016 the provider was working below the recommended amount of staff they had identified. For example, on the day of inspection the registered manager told us they should have a minimum of five staff on each day shift, they told us they had identified these levels using their staffing dependency tool. When we arrived there were four staff on duty. The registered manager confirmed this was not enough to support the needs of the people living at the service. They told us they were trying to recruit to the vacancies which they had clarified as a minimum of five full time care staff. We looked at rotas and this showed us that the provider had worked below the recommended numbers for several weeks and they were working below these numbers for the remainder of the rota that was available.

During the inspection the provider made arrangements to cover the shortfalls for the next 72 hours to ensure that the service was safe. This was following our recommendation as they had not taken action to identify the shortfalls. It was also agreed that the provider would send a copy of their planned rotas on a weekly basis to us to demonstrate they were providing the correct staffing levels.

This is a continuing breach of Regulation 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014.

Risks to people's safety were not managed in a safe way. Before the inspection visit we received information that a person had fallen and this had not been identified by the provider. The assisted technology this person used to keep them safe had not been turned on. The registered manager confirmed this incident had occurred. We spoke with the deputy manager about this and they told us what action they had taken, this included the introduction of a 'check sheet' to ensure that the assisted technology was turned on. We looked at records for this person; we saw there was a risk assessment in place identifying this person was at 'medium' risk of falls. However following this fall this had not been reviewed and action had not been taken to reduce the risk of the person falling again. The deputy manager confirmed this had not been reviewed. We also saw other falls had been recorded in the 'falls diary' and the risk assessments for these people had not been reviewed. We looked at the 'check sheet' that had been put in place by the provider. This stated it was to be completed when 'seniors are going off duty and senior coming on duty'. However, the sheet had only been completed twice in a 29 hour period. In addition we looked at the sensor equipment in the person's bedroom. This was not switched on. A staff member told us that when the person was not in their room the equipment was turned off. They confirmed there was no system in place to ensure it was switched back on when the person entered their room. This meant that the system that had been implemented was

not effective to ensure people had the suitable equipment they needed to keep them safe.

We saw that one person had a temporary health condition which affected their mobility. The person was now unable to mobilise unaided. A staff member told us, "[Person] would need staff support". We looked at records for this person and we did not see this had been considered. This person chose to remain in their bedroom, however they could not reach their call alarm. A visiting health professional told us they had identified this to the staff the previous day; however no action had been taken. We spoke with the management team regarding this who confirmed no action had been taken. In addition we saw this person had fallen six times over a three week period and the provider had not taken any action to reduce the risks for this person.

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

Following the comprehensive inspection in May 2016 we took action to ensure the provider did not admit any person to the service, without the prior written agreement of the Care Quality Commission. We judged that the way in which the provider was failing to meet the requirements of regulations meant that people were being exposed to the risk of harm. This included any re-admissions to the service, for example from hospital. This restriction applied to any person who had been resident at the home at any time. At the focused inspection it was identified that a person had been admitted to hospital, they had spent up to five days in hospital and had then returned to Bearnett House. The provider had not notified us about this and had not obtained prior written agreement as directed in the notice of decision. We spoke with the registered manager about this they confirmed that the person had been readmitted without this specific permission. They told us they were initially unclear of the notice of decision however they were now aware they should not do this and would not do this in the future.

This is a breach of the registration condition as the provider had failed to gain permission from us for any new admission or re-admission to the service.