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Bearnett House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection visit took place on the 22 January 2018 and was unannounced.

Bearnett House is a care home. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Bearnett House is registered to accommodate 25 people in one adapted building. At the time of our inspection 17 people were using the service. Bearnett House accommodates people in one building and support is provided on two floors. There is a communal lounge, a dining area, a library and conservatory and a garden that people can access. Some of the people living at Bearnett House are living with dementia.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when; to improve the key questions safe, effective and well led to at least good. The provider did not initially return the action plan as requested however when we requested this action plan again this was returned. When we completed our previous inspection on 31 May 2017 we found concerns that risks to people were not always managed in a safe way. People were not always supported in line with recommendations. We also found concerns with medicines management. Mental capacity assessments had been completed; however they were not individual or specific to the decision that was being made, and decisions were not always made in people's best interests. People were not always offered the opportunity to participate in activities they enjoyed and felt there could be more to stimulate them. We also found people's records had not always been completed to provide the information so they could receive personalised care. We could not be sure the systems in place were effective in identifying areas of improvement. The provider had not always ensured there was a suitable recruitment process in place. We have previously taken enforcement action against this home and there is currently a Notice of Decision in place and people cannot be admitted into the home without the written permission of the CQC.

At this inspection people are not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service do not support this practice. Risks to people are not managed in a safe way and when needed action was not always taken to ensure people were safe. When people displayed behaviours that may challenge we could not be sure the behaviour management plans in place gave staff the information to offer a consistent approach. Medicines were not always administered as prescribed. Staff demonstrated an understanding of safeguarding however we could not be assured all incidents had been fully considered.

Complaints were not always responded to in line with the provider's policy. When health professionals made recommendations these were not always followed. When employment checks had been completed the provider had not assured staffs suitability to work within the home. There were no systems in place so that lessons could be learnt when things went wrong. The audits completed did not drive improvement within the home. The provider had not made or sustained the necessary improvements since the last inspection.

There were staff available however interactions were often task focused and people felt they could be more to do. People were not always offered choices or received care that was individual to them. People's cultural or dementia needs were not always fully considered. Staff received training however we could be assured their knowledge in these areas was checked

Infection control procedures were in place and implemented within the home. People's privacy was considered. People and relatives were happy with the staff and were free to visit anytime. People enjoyed the food and had access to GP and other health care professionals when needed. The home was clean and decorated to consider people's preferences. The provider was displaying their rating as required.

The overall rating for this service is Inadequate and the service is therefore 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.

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 always safe.
Risks to people were not always considered or action taken when needed. Staff were not always available and care was task focused. Staff did not have time to spend with people. Improvements were needed as to how medicines were administered. Staff knew what constituted abuse however we could not be sure all incident were considered. There were infection control procedures in the home and these were followed.

Is the service effective?

Requires Improvement

The service was not always effective.
People's capacity had not been fully considered and when restrictions were placed upon people staff did not have the information available to support them. Recommendations that were made by health professionals were not always followed. The training staff received did not always help them to support people and their knowledge was not always checked. People enjoyed the food and were offered a choice. The home was decorated in accordance with people's preferences.

Is the service caring?

Requires Improvement

The service was not always caring.
People were not always offered choice. People and relatives were happy with the staff. Relatives felt welcomed and were free to visit anytime. People's privacy and dignity was upheld.

Is the service responsive?

Inadequate

The service was not responsive.
People did not receive individualised care and action taken was not responsive to their needs. People's cultural needs were not considered. Complaints were not responded to in line with the provider's procedure. The provider had not fully considered how to offer support to people with dementia and people were not offered the opportunity to participate in activities that offered them stimulation. No one in the service was receiving end of life care.

Is the service well-led?

Inadequate

The service was not well led.
Concerns have been identified about the provider as they have not sustained the improvements they have made. The providers remains in breach of regulations and have not made the necessary improvements needed to comply. There are concerns with the management of the home and the lack of leadership. The provider had not notified us about all significant events within the home. Audits were not driving improvements . Recruitment procedures in place did not ensure staff were safe to care for people. Staff did not always feel supported or listened to. The provider was displaying their rating in line with our requirements.

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 22 January 2018 and was unannounced. The inspection visit was carried out by two inspectors and a specialist advisor. (SPA) The SPA that we used was a specialist in The Mental Capacity Act and DoLS.

The inspection was informed by feedback from members of the public, whistle blowing information and health professionals. They pointed out some concerns about the care people received within the home and the staffing levels. Concerns were also raised to us about how complaints were managed. Due to the information that we received we made the decision to bring forward our comprehensive inspection.

We also 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. We spoke with the local authority contracts and quality monitoring officer who had completed a recent inspection and gained their feedback. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to formulate our inspection plan.

At the inspection we gave the provider the opportunity to send us any audits they were completing that were unavailable during our inspection. We asked for this information to be provided the following day after the inspection. At the time of writing this report we have not received any additional information from the provider for us to consider.

We spent time observing care and support in the communal areas. We observed how staff interacted with people who used the service. We spoke with three people who used the service and three relatives. We also spoke with four members of care staff, a member of the kitchen staff and the acting manager. After the inspection we received further positive feedback from relatives of people who lived at Bearnett House. We

did this to gain people's views about the care and to check that standards of care were being met. Four of the providers or their representatives were available during the inspection and for feedback.

We looked at the care records for seven 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 audits carried out within the home, staff rosters and actions plan that were in place. We also looked at staff files so we were able to review the provider's recruitment process.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found risks to people were not always managed in a safe way. People were not always supported in line with recommendations. Guidance for as required medicines were not always in place so we could not be assured people had received these medicines when needed. When people refused medicines there was no guidance in place for staff to follow. This was a continued breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found previous improvements that had made had not always been sustained and further improvements were needed. We did find some areas of improvement with how medicines were managed however, we found new areas of concern. The provider has now been in Breach of Regulation 12 for seven inspections since October 2015.

People did not always receive their medicines as prescribed. We saw one person was prescribed a tablet that they should receive at 8am, 12pm and 4pm. This was clearly documented throughout the person's records. We saw the 12pm medicine was administered at 1.13pm. When we spoke with staff they told us this was as this person had received their medicines late during the morning. (The 8am dose) There was no system in place and the time the person received this was not documented. The acting manager confirmed they should have received these medicines at 8am and 12pm. This meant we could not be sure the effectiveness of this medicine as it was not given at the correct time.

When people were at risk of falling we saw that the guidance in place to keep people safe was not always followed. For example, we saw that one person was at medium risk of falls. Staff told us and the records we reviewed confirmed that this person was to be supervised when mobilising and that a staff member should be available in the communal area at all times when they were present. The PIR that the provider sent to us also stated 'We have reviewed our risks for those residents, and now ensure a member of staff is on duty in the lounge at all times'. During our inspection we observed this person was in the lounge without staff support for over thirty five minutes. During this time we saw this person tried to stand independently. Furthermore, when we reviewed falls that occurred within the home we saw this person had fallen six days before our inspection and this had been unwitnessed. This meant the measures that had been put in place to help reduce the risk of this person falling were not followed. We raised concerns about unsupervised communal areas with the provider following our inspection in December 2016 and found at our last inspection improvements had been made; however, they had not been sustained at this inspection.

When incident or accidents occurred within the home action was not always taken to reduce the risk of recurrence. For example, we saw that another person had fallen. This person had a motion sensor in place to alert staff when they were mobilising. We saw documented that the sensor had not activated when the person mobilised. We checked what action had been taken following this. Although the batteries were replaced, there was no system in place to check this equipment or ensure it was turned on. We spoke with the acting manager who confirmed this to us. During our inspection we saw this piece of equipment was not turned on, however the person was not present in their room. At our last inspection following previous concerns raised we saw a system had been introduced to check this equipment was in place and working. At this inspection this system was no longer being used. This demonstrated to us that the provider was not always effectively implementing and monitoring systems to ensure that people were safe. When incidents

occurred or things went wrong within the home there were no current systems in place so that improvements could be made and lessons learnt. We spoke with the acting manager and provider who confirmed they were not currently completing this.

Staff and relatives told us about two separate incidents that had occurred during our inspection. Neither incident was documented in any notes we reviewed or discussed in handover. When we spoke with some staff about this they were unaware these incidents had occurred. The acting manager could not provide an explanation as to why this information hadn't been shared with the staff team. This meant we could not be sure that all incidents that occurred within the home were recorded and shared with staff so that they could monitor the situation and take action if necessary.

We saw plans were in place to respond to emergencies. These plans provided guidance and information on the levels of support people would need to be evacuated from the home in an emergency situation. However, when people's needs had changed they had not always been reviewed or updated to reflect this. For example, one person's mobility had changed following a fall and a hospital admission the plan had not been updated to reflect this. This demonstrated risk assessments were not always reviewed to reflect people's needs.

When people displayed behaviours that may challenge there was not always the relevant guidance in place and staff offered an inconsistent approach. For example, we looked at records for one person. It was documented that staff should be aware of triggers for this person, however there was nothing documented as to what the triggers for this person may be. We spoke with the acting manager who explained to us what these may be. When we spoke with another member of staff they gave a different example as to what may trigger this person's behaviour. As staff did not always have the relevant information available to support people we could not be assured how this was managed or that they offered a consistent approach. Furthermore, an incident occurred during our inspection with a different person. We checked their records and we did not see any information documented about the behaviour that had occurred. A relative and staff confirmed this person had previously displayed these behaviours. This meant when people had behaviour that may challenge, staff did not always have the guidance available to offer a consistent approach.

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

We received mixed views about staffing levels within the home. One person said, "I think there are enough staff". A relative told us, "There are lots of staff". During our inspection we saw that staff were busy and interaction with people was often task focused; for example, when people needed support with meals or personal care. We observed in the communal area there were times where staff were not present and people slept for long periods. Staff told us they would benefit from more staff. One staff member said, "There are enough of us, but we don't have the time we would like to spend with people so sometimes things are a little rushed". The acting manager told us they used a dependency tool to work out staffing levels within the home and were confident there were enough staff available for people. However, we saw that they were not always deployed to meet people's needs.

Staff knew what constituted abuse and what to do if they suspected someone was being abused. A member of staff said, "It's reporting any kind of concern or abuse". The staff member went on to confirm they had received recent training and they knew how to report any concerns. Procedures were in place to ensure any concerns about people's safety were reported appropriately to the local authority. We saw that the provider had raised some safeguarding concern's however we could not be assured all concerns were reported appropriately. Since our last inspection we had received whistle blowing information about safeguarding

incidents that had occurred within the home. When we contacted the home they confirmed to us these incidents had occurred and had not been considered as safeguarding. On our request these were reported and investigated by the local authority which demonstrated to us that the provider did not always recognise what constituted abuse and potential safeguarding.

There were infection control procedures in place within the home. We saw an audit was completed by the provider in this area. Since our last inspection there had been a health outbreak within the home, the provider told us the action they had taken and how they had contacted Public Health England for guidance and advice as required in this instance. Staff told us and we saw protective equipment including aprons and gloves were used within the home. We also saw the provider had been rated as five stars by the food standards agency; this is the highest rating awarded. Staff confirmed to us they had received the relevant training needed to work within the kitchen environment. The food standards agency is responsible for protecting public health in relation to food.

We saw staff administering medicines to people. The staff spent time with people explaining what the medicine was for. When people had medicines that were on an 'as required' basis we saw this was offered to them first. We saw there was guidance available for staff to ensure people had these medicines when needed. When people refused medicines we saw there was guidance in place for staff to follow.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, 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 provider has now been in Breach of Regulation 11 since our first inspection in October 2015.

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 the MCA. We saw some capacity assessments were in place. These were in relation to every intervention that was being completed with the person for example, 'putting in their hearing aid on a daily basis' and 'ordering incontinence aids'. We were unsure why these areas were being assessed and demonstrated that there was limited understanding of when people's capacity should be assessed. We also found when capacity should have been considered for restrictions on people's freedom it was not. For example, when people were using bed rails or sensors these areas had not been assessed. When capacity assessments had been completed they did not show how the decisions had been made and it was unclear what the decision was. The capacity assessments we looked at were all the same and the wording in each area of assessment was repeated. This demonstrated to us that the provider had not taken an individualised approach. When people lacked capacity to make decisions for themselves we saw there were best interest sheets in place however there was no information to show how or why the decision had been reached. Although staff told us they had received training in MCA the staff we spoke with were unable to demonstrate an understanding. One staff member said, "If someone can't make a decision for themselves we would refer them to the memory clinic". Another staff member told us, "If someone has dementia they can't make any decisions for themselves". Furthermore we saw some relatives had consented on people's behalf's when they did not have the legal power to do so. This demonstrated that the principles of the MCA were not fully understood or considered.

We saw that the provider had considered when people were being restricted unlawfully and application to the local authority had been made. 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.

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

The provider did not always follow health professional's advice to keep people well. One person had previously fallen in the home and this had resulted in a hospital admission. Due to a condition on the

provider's registration they had to ask CQC for permission for this person to return to Bearnett House. Whilst this person was in hospital a physiotherapist completed an assessment and identified this person was to transfer using a specific piece of equipment. We had agreed that this person could be discharged from hospital and would be supported using this equipment. During our inspection staff told us and we saw this person was not transferred using this equipment. We spoke with the acting manager who told us this was as this person's mobility had improved and they no longer required it. They confirmed that the physiotherapist had not offered advice on this and the home had made the decision to stop using this equipment. We saw that a second person had been assessed by a health professional in July 2017. It was advised that they should trial a piece of equipment to support them to transfer for a two week period. We discussed this with the acting manager and the provider who confirmed that they had not completed this. This meant when referrals had been made to health professionals recommendations that were in place were not always followed and people were not always supported in line with up to date legislation.

Permanent staff received an induction and training that helped them to support people. The acting manager and provider confirmed that when agency staff were used within the home an induction was not completed and they were not offered any additional training by the provider. Although staff told us the training they received helped them support people, we could not be assured how effective the training was. For example, staff told us they had received MCA training since the last inspection. Staff did not demonstrate to us an understanding in this area and the provider was not checking staff competency's after training had occurred to identify areas of concern or if further work was needed. This meant we could not be sure the training given helped staff to support people as needed. The provider was checking staff competencies in some area for example, the management of medicines. The acting manager told us they were completing these competencies for staff. They confirmed they had not received any additional training in this area and their competency had not been checked and they were unsure if they should be completing these. This meant we could not be sure competency checks were being completed correctly.

People enjoyed the food and were offered a choice. One person said, "The food's nice; it has always been of a good quality". When people had preferences they told us and we saw this was catered for. We saw one person request a specific meal for lunch and they received this. We saw people were offered a choice and had different meals. At breakfast we saw some people had hot cooked breakfasts whereas others had cereals. There were cold drinks available for people and during the day we saw people were offered hot drinks and snacks. 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 when needed people had access to the GP or the chiropodist. We saw the GP visited during our inspection as some people in the home were unwell.

The home was clean and decorated in accordance with people's preferences. People's personal belongings were in their rooms, including photographs of people who were important to them. Chairs had been adapted in communal areas so they were the correct height for people to use. There was a garden area that was suitable for people to use and in the summer people confirmed they liked to go outside.

Requires Improvement

Is the service caring?

Our findings

People were not always offered choices. We saw when people were at risk the action the provider had taken to keep them safe was service led and not individualised to the person. For example, when people were at risk of falling it was documented for some people that when they were awake they should bring them up to the reception area so they could be supervised. There was no consideration to what these people may choose to do and if they wished to spend time in other areas. We saw during our inspection these people were in the communal areas. They were unable to tell us about their experiences. Furthermore, staff told us that people no longer had their breakfast in their bedrooms and all people had to come to the communal area for this. This was again to reduce risk for people. During the inspection we also saw that a member of staff tried to put a protective apron on a person at mealtime, no communication or explanation was offered to the person by the staff member. This resulted in an angry outburst from the person. This meant people's choices were not always respected to give them individualised care

People and relatives spoke positively about the staff. One person said, "I find the staff are wonderful. I couldn't fault them in any way" A relative told us, "They are all very caring". Another relative said, "The staff are caring, patient and respectful". When staff had time to spend with people, for example at mealtimes we saw positive interactions and people were treated in a kind and caring way. For example, we saw a staff member support someone to clean themselves when they had spilt some food. Relatives told us they could visit at any time. One relative said, "I feel involved with the home and they always keep me updated. I come every day so I know them and they know me. They are always very friendly and everyone can't do enough for me".

People's privacy and dignity was promoted. One person said, "They always give me a shout before they come in my room that's nice". Staff gave examples of how they treated people with respect and promoted their privacy and dignity. One staff member said, "We knock on doors and use the curtains when we are in shared rooms". We saw staff asked people if they would like to use the bathroom discreetly, when needed. When people were supported to use specialist equipment we saw people's clothes were adjusted so their dignity remained.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found people were not always offered the opportunity to participate in activities they enjoyed and felt there could be more to stimulate them. We also found people did not always receive personalised care. At this inspection we found improvements had not been made and further areas for improvement were needed.

People did not always receive care that was responsive to their needs. For example, we were told by the acting manager that all people living at Bearnett House had been placed on a high calorie diet. This included adding additional nutrients such as powdered milk to full fat milk to increase people's daily calories. The acting manager's rationale for this was that everyone in the home had lost some amount of weight. On discussion with the acting manager and staff it was suggested that the weight loss maybe due to a problem with the weighing equipment within the home and not to do with people's diets. We did not see documented that this had been discussed with people and guidance had not been sought from health professionals before making this decision. This meant the provider had not considered people's individual needs or preferences before making this decision.

We saw that a person had lost significant weight. The provider had referred this person to a dietician for advice. Following this we saw that a weight chart had been introduced for this person and they were being weighed weekly. We saw this had now been changed and staff we spoke with confirmed this to us. Staff and the acting manager told us this was as the person was increasing in weight. However when we looked at records the person continued to lose weight. This meant the action the provider had taken was not always accurate and responsive to people's needs.

People's cultural needs had not been considered. The provider confirmed this was not something they assessed or considered for people living within the home. The provider told us they had an equality and diversity policy in place, we gave the provider the opportunity to show this to us however we did not see this during our inspection.

This is a breach of Regulation 9 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Complaints were not responded to in line with the provider's procedure. Prior to the inspection we had received information of concerns as to how a complaint had been responded to. We reviewed this as part of our inspection and found the areas that had been addressed in the complaint had not been responded to in the response the provider had made. The response had not been completed in the 28 day time frame that was set out in the provider's procedure. We spoke with the complainant before our inspection and they were unhappy with the response by the provider. We spoke with the provider about this and they were unclear about what action they should have taken and what the complaint was about. We raised concerns about how complaints were managed following our inspection in December 2016 when the provider was in breach of this regulation. At our last inspection improvements had been made in regards to managing complaints however these had not been sustained at this inspection and the provider in again in breach of Regulation

16.

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

People who were living with dementia were not always provided with the support they required. People were asked what they would like to eat before the mealtime but there were no pictures or prompts used to support these people to make their choices. We also observed that one person was becoming distressed as they thought they had not received a drink and the staff told us this was a regular behaviour. We saw that staff approached this differently and did not offer consistent support to this person to distract them from this request. We saw there was no information within their plan of care to support the person with this behaviour.

The provider confirmed they were unaware of accessible information standards (AIS) and were not implementing this within the home. AIS were introduced by the government in 2016 to make sure that people with a disability of sensory loss are given information in a way they can understand. We looked at one person's file it stated they had hearing difficulties. A communication care plan was in place however it did not detail any further interventions for example photographs or pictures. The advice recorded was that staff speak loudly.

At the last inspection people felt there could be more activities in the home and there was a lack of stimulation. At this inspection we found the same concerns. One person said, "I find myself sleeping a lot as there isn't much to do". There was no activity co-ordinator in post. We were told by the acting manager and provider that staff supported people with activities. The activity board stated that the activity for that day was playing cards; we did not observe this taking place. We asked staff about activities and they told us people were watching a DVD. We saw out of the 12 people who were in the room, nine people were asleep and a further two were unable to see the television. This meant that people did not always have the opportunity to participate in activities they enjoyed or that people received stimulation to keep them occupied.

At this time the provider was not supporting people with end of life care, so therefore we have not reported on this at this time.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found the systems in place were not always effective in identifying areas of improvement. The provider had not always ensured there was a suitable recruitment process in place. This was a continued breach of Regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection the provider had not made the necessary improvements and further concerns were identified.

Since our first comprehensive inspection on 8 October 2015 the provider has continued to be in breach of Regulation 11 and 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. We have now inspected this location on seven separate occasions during this time. Despite two meeting with the providers and five action plans we have found that the provider has not made the necessary improvements to comply with these regulations. We have previously taken enforcement action against this home and there is currently a Notice of Decision in place on this service and people cannot be admitted into the home without the written permission of the CQC.

In the action plan dated 12 July 2017, the providers again gave us assurances they understood and could meet the legal requirements under regulation 11 and 12. The action plan in relation to regulation 11 stated, 'All care plans are in the process of being implemented with an individual decision, where support is required'. We saw this action would be completed in August 2017. The PIR the provider completed on 8 December 2017 stated, 'Staff have undergone training, and so should have a good knowledge of the deprivation of liberty safeguards (DoLS) and the Mental Capacity Act. This is to ensure that of our residents treated in the same way and their best interest, values and beliefs are respected.' At the inspection although we found some 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.

Furthermore, when improvements have been made these are not sustained. For example at the inspection in December 2016 we identified concerns with how complaints were managed within the home, this was a breach of Regulation 16 of the Health and Social Care Act 2008. At the next comprehensive inspection in May 2017 we found improvements had been made in this area. At this inspection we have found new concerns with how complaints were managed and the provider is again in breach of this regulation. This demonstrated the management systems in place were not driving improvements and were inconsistent.

We saw that some audits were completed within the home however they were not always effective in identifying areas for improvement. For example, we saw that audits were completed in relation to falls within the home. There was an analysis section to this that had not been completed since before June 2017.There was no information to identify, how many falls had occurred and how many falls were during night. We did not see how this information was then used to drive improvement within the home. We did not see how the provider used information within the home to learn and improve.

When incident or accidents occurred this information was not considered or used to make improvements

for the people living at Bearnett House. We saw and the acting manager confirmed that when an incident occurred there was no information available so that lessons could be learnt or improvements made. The acting manager confirmed that accidents or incident forms were filed away into individual's files without further action always being taken. We showed the acting manager one form where no action had been considered and they confirmed this to us. For another person who was at risk of falls we saw although the risk assessment had been reviewed nothing else had been considered as to how to support this person.

At the comprehensive inspection on 7 December 2016 and 31 May 2017 we highlighted concerns with the provider's recruitment process. At this inspection we found that when information had been received by the provider about staff's potential lack of suitability to work within the home they had not completed the necessary checks and relevant risk assessments. We also found for some staff that suitable references had not been obtained. This meant the provider does not have a suitable recruitment process in place.

We saw that a survey had been completed to capture the views of relative and friends of people who used the service. This information was displayed in a graph in the communal area. Where areas of improvement had been identified we did not see what action had been taken to make the improvement. We could not see what action had been taken to make the improvements or how this had been shared with people or their relatives.

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

The provider had not notified us of all significant events that occurred within the home, as they are required to do. For example, a serious injury had occurred with the home and there had been a health outbreak. Prior to our inspection we also received information from the public about an event that had stopped the service; we had not received information about this. We requested this information from the provider which they subsequently sent to us.

This is a breach of Regulation 18 (2) (b)(g) of the Care Quality Commission (Registration) Regulations 2009

There was no registered manager in post and one has not been registered with us since February 2017. We have written to the provider to seek reassurance in relation to this. A new manager had been appointed at the home but had recently resigned. Another new manager is due to commence post in March 2018.

The staff we spoke with voiced concerns collectively that there has been lots of instability around the management of the home. They all spoke positively about the previous manager and voiced disappointment that they had now left. Staff acknowledged that the acting manager was temporary and were awaiting the new manager to start. Staff gave mixed views about the support they received. One staff member said, "I feel supported and happy with how things are". Whereas another staff member told us they didn't have regular supervisions. Another staff member told us they had requested refresher training on several occasions but had not had a response. This meant we could not always be sure staff were listened to and action taken.

We saw that the rating from the last inspection was displayed around the home in line with our requirements. The provider does not have a website to display their current rating.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us about all significant events within the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive individualised care and action taken was not responsive to their needs. People's cultural needs were not considered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity had not been fully considered and when restrictions were placed upon people staff did not have the information available to support them.

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 always considered or action taken when needed. Medicines were not always administered as prescribed.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 16 HSCA RA Regulations 2014

personal care	Receiving and acting on complaints Complaints were not responded to in line with the provider's procedure.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Concerns have been identified about the provider as they have not sustained the improvements they have made. The providers remains in breach of regulations and have not made the necessary improvements needed to comply. There are concerns with the management of the home and the lack of leadership. Audits were not driving improvements . Recruitment procedures in place did not ensure staff were safe to care for people.