Mrs Judith Dena Griffin

Bearwood House Residential Care Home

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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

We inspected this service on 19 February 2015. The inspection was unannounced. At our previous inspection in October 2013, the service was meeting the regulations that we checked.

The service provides accommodation and personal care for up to 21 people. Twenty two people were living at the home on the day of our inspection. We have made reference to this in the body of our report. There was no registered manager in post at the time of our inspection and we are currently in the process of removing the names of two former registered managers. The registered provider did not contact us to let us know that the registered manager had left and what steps they were taking to recruit a new manager and failed to comply with a condition of registration. A newly appointed manager was working at the service on the day of our inspection and planned to register with us straight away. We refer to the new manager as the manager in the body of the report.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 told us they felt safe living at the home. People were protected against the risk of abuse, as the manager and staff understood their responsibilities to protect people from harm. Risks to people's health and welfare were assessed and care plans were in place to minimise the identified risks but some people's care did not reflect what was detailed in their care plans.

People were not being protected against the risks associated with unsafe or unsuitable premises. We found concerns with safety relating to signage for fire exits, safety on the stairways and access to bathrooms for people using wheelchairs.

People who lived at the home told us they did not have to wait long for staff to respond when they asked for support. Staffing levels were monitored weekly by the manager to ensure people's needs were being met.

The recruitment processes demonstrated that sufficient checks had been completed to ensure staff were suitable to work in a caring environment. Staff told us they received training and some had achieved a nationally recognised qualification in health and social care. Staff had not received supervision since the registered manager left. The manager told us they planned to re-start supervision and establish what training had been done and what needed to be updated.

Staff knew the people they were supporting and treated them with kindness, compassion and respect. However, improvements were required to make sure people's dignity was respected and promoted at all times.

We identified inconsistencies regarding how and when a person's mental capacity to consent to care or treatment is assessed and recorded, and how their rights are protected when decisions are made on their behalf. People we spoke with told us they were able to make day to day choices about food and bedtime preferences but they were not aware they could consent to their care and treatment.

Some people's needs and preferences were not being met. People told us they were not offered a bath as frequently as they would like and there were no regular arrangements in place to involve people in hobbies, activities or outings which interested them.

People told us they enjoyed the food at the home. Improvements were needed to ensure that people's dietary needs were monitored and updated to meet their changing needs.

People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the home.

The manager told us that the provider had submitted an application to vary the number of people the home could accommodate from 21 to 26 people. On the day of our inspection there were 22 people living at the service.

The registered provider had not carried out any checks to assure themselves that the quality of the service was being maintained in the absence of the registered manager. People's nutritional risks were not monitored effectively. People received their prescribed medicines but improvements to the recording of medicines was needed to protect people from receiving out of date medicines. There was no suitable system in place to ensure people who used the service would receive pain relieving medicines at night when needed. Information from accidents and incidents was not used to identify trends which could have an impact on how people's care is delivered. Information from complaints was not analysed to make improvements to the service where needed and there were no arrangements to gather feedback from people on the quality of care they were receiving.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of the full version of this 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 consistently safe.

Environmental risk assessments were not in place to protect people against the risk of unsafe or unsuitable premises. Risks to people's health and welfare were identified and their care plans described the actions that needed to be taken to minimise their identified risks. People were protected from the risk of abuse because suitable recruitment procedures were in place and staff knew how to safeguard people from abuse

Requires Improvement

Is the service effective?
The service was not effective.

The Mental Capacity Act 2005 Code of Practice and the Deprivation of Liberty Safeguards were not being followed when assessing and recording people's capacity to consent to care or treatment, and when making best interest decisions. There were no arrangements in place for people to access advocacy services to help them communicate their wishes. People told us they enjoyed their food at the home. People were supported to access other healthcare services when they needed them.

Requires Improvement

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

Staff respected people's privacy but did not always promote their dignity when responding to people's requests for support with personal care or when administering medicines. People told us they were well cared for and we saw that staff were kind and patient when providing support to people. Staff knew people well and understood their likes, dislikes and preferences for how they should be cared for and supported.

Requires Improvement

Is the service responsive?
The service was not responsive.

Some people's support was not provided as identified in their care plan which meant that it did not always meet their individual needs or respect their preferences. People made choices about their daily routine in the home but they were not supported to follow their interests and take part in social activities. People knew how to complain but complaints received were not consistently recorded and investigated.

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

The provider was in breach of their registration by accepting more people at the home than they were registered for. There was no registered manager

Inadequate

Summary of findings

employed at the home. There were no audits in place to monitor the quality of care in the home. We found problems with the monitoring of people's nutritional needs and the recording and administration of people's medicines. There were no arrangements to seek people's views on the service and no analysis was made of accidents, incidents or complaints to improve the quality of care people were receiving.

Bearwood House Residential Care Home

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 19 February and was unannounced. This inspection was conducted by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service.

We reviewed the information we held about the service. We looked at information from local authority commissioners and the statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

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

We observed care being delivered in communal areas and we observed how people were supported at lunch time. We looked at care records for four people, four staff recruitment files and documents associated with the management of the home.

On this occasion we had not asked the provider to complete a Provider Information Return before the inspection but we give the provider the opportunity to provide us with information. The Provider Information Return asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at the home. People said, "Yes I feel very safe". One relative told us their relative had fallen in their room shortly after coming into the home.. They told us that they had been discharged from hospital with very little information about their needs and without any walking aids. They were happy with the action taken following the fall and told us they had been kept fully informed by the manager.

Staff told us they had completed safeguarding training as part of their induction. Staff we spoke with were able to describe the signs of abuse and knew what actions they should take if they had any concerns about people's safety. One member of staff told us, "If I saw anything that I thought was untoward I'd report it to the manager straightway". This meant the staff understood their responsibilities to keep people safe.

During our visit we saw problems with access and egress at the home. A fire exit off the dining room was not clearly signed, there were stair gates missing on the staircase leading to the top floor and there were no barriers to prevent people living at the home from going down a set of stairs that were not in use. We also saw that there were some problems getting in and out of one of the bathrooms as a person living at the home called for help when they couldn't get out with their walking frame because the door did not open outwards. The manager told us that remedial action was in hand to address trip hazards in the dining room and at the entrance to the lift and that access for wheelchair and frame users would be improved by the new wet room that was almost complete. However, they were unaware of the hazards we had identified and there was no evidence that they had conducted a premises risk assessment to protect people against the risks associated with unsafe or unsuitable premises.

We asked the manager how staffing levels were planned at the home. They told us that staffing levels were reviewed weekly based on the dependency levels of people who used the service. The manager also told us that they had responded to concerns raised by staff that they needed additional help during the morning and early evening and recruited an additional member of staff who would be starting when their pre-employment checks had been completed. Everyone we spoke with told us they felt safe and that they only waited a few minutes for staff to come to help them when they pressed their call bell. The district nurse told us they thought there were more staff since the manager had started. They said "Things have picked up, there are more staff now, you could never find anyone before".

Staff told us and the recruitment records we saw confirmed that suitable recruitment procedures were in place which included following up references and undertaking Disclosure and Barring Service (DBS) checks before staff started work at the home. The DBS is a national agency that keeps records of any criminal convictions. Care records showed that risk assessments and care plans were in place to minimise the identified risks to people and we saw that staff followed them when helping people to move around the home. For example, we saw staff call their colleagues for assistance for people who needed more than one person to help them to transfer safely from their walking frame to a chair.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with had an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). One member of staff told us, "Everyone has capacity unless assessed as otherwise", and that the legislation, "Protected people's rights". People we spoke with were not aware they could consent to their care and the manager told us there were no arrangements in place for people to access advocacy services. This meant that people living at the home were not always being supported to communicate how they wanted to receive their care and treatment, if they were not able to speak for themselves.

We asked staff about a person we had seen attempting to leave the home who was being ushered away from the door by the staff . They told us the person had left the home unaccompanied and they now needed to be, "Watched" and that they, "Wouldn't let them go out". We looked at the person's mental capacity assessment but this had conflicting information recorded as it stated that the person had capacity but lacked the ability to evaluate risk. We asked the manager about the assessment and they told us that it had been completed by the previous manager. They told us they had not reviewed the assessment or made a DoLS application and were not aware that the actions they were taking to keep the person safe might be a deprivation of their liberty. This meant that people's rights were not being protected when decisions were made on their behalf.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff we spoke with told us they had received an induction when they started work and that they shadowed another member of staff for three shifts to enable them to get to know people who used the service. Staff told us they received training and some had undertaken a national qualification in health and social care. Staff told us they had not received supervision since the registered manager left. The manager told us they would be starting sessions soon and they were already working with staff to establish what training had been done and what needed to be updated. This would ensure that people were cared for and supported by suitably skilled staff.

All the staff we spoke with were able to tell us about people's needs and abilities and their descriptions matched what we read in their care records. For example, one member of staff told us about how they needed to get down on their knees to be on the same level at one person and another person had a soft toy to comfort them. People who used the service told us staff offered their support when they needed it. One person added, "They [staff] keep an eye on me and make sure I don't do anything silly."

People we spoke with were positive about the food and told us there was a choice. One person said, "The food is good, there is a menu" and "If you don't like what's on offer they will do something else". Staff we spoke with knew about people's likes and dislikes. At lunchtime we saw meals were served to people one at a time from the kitchen. The food looked nice and smelt appetising. We observed that people could choose to have their meals in the dining room or the lounge where they were sitting and we saw the staff taking meals to people in their rooms. We observed that staff did not spend time with people whilst they were eating but we saw that most people were able to finish their meals without support and were not rushed. The manager told us visitors could have a meal with their relatives if they wished. One relative told us, "Meals are really good here".

People told us that they could see their GP whenever they wanted and were supported to go to hospital appointments. We saw that the district nursing team visited some people daily. We were informed there had been problems with the management of wounds at the home in the past, but this had improved and care records we saw showed that tissue viability plans were regularly reviewed and action taken was recorded in the daily logs. Care records we looked at also showed that people had been able to see the dentist, chiropodist and optician to meet their ongoing healthcare needs.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us they liked living at the home. One person said, "The girls are lovely here, you've only got to mention something and it's there." All the people we spoke with told us the staff were kind to them. One person said, "Staff treat me well would tell someone if they didn't."

Some of our observations showed that staff did not always promote people's dignity. We saw one person had to lift their trouser leg to alert the staff that their catheter bag needed emptying. The member of staff didn't pull it down when they were helping the person to transfer from a chair. At lunchtime, we saw a staff member approach one person announcing their intention to administer eye drops, but the person pushed their hand away and continued to eat their meal. Although the staff member went away saying they would try later, their actions in trying to administer the eye drops at the dinner table had not respected the person's privacy or dignity.

Other observations we made demonstrated the staff were caring and patient when they assisted people to move around independently in the home. We saw one person wanted to get into a chair using their frame. The member of staff said to them, "You must feel like you've walked for miles….that's it you're nearly there". Once the person was comfortable, the member of staff moved away, leaving the frame within reach, to ensure they had their equipment to hand and could remain independent.

Care records we looked at included information about people's history and we observed staff talking to people about their lives. For example, we heard one member of staff talking to a person about a sport they'd enjoyed when they were younger. People were able to choose when they got up in the morning and what time they went to bed. Most people told us they preferred to go to bed early, but they could stay up and watch a late film on television in the lounge if they wished.

The manager told us that visiting times were not restricted and relatives we spoke with told us they were could visit at any time and always felt welcome.

We saw staff knocked on people's doors and announced who they were before entering. We saw that people's legs were covered with a blanket, which protected their dignity when they were being supported with a transfer.

Requires Improvement

Is the service responsive?

Our findings

People told us that they were sometimes bored which meant that some aspects of the service were not responsive to people's needs. One person told us, "You do get fed up doing nothing". Most of the time we saw that there was little interaction between staff and people who used the service. We observed that people were left for long periods of time without any interaction from staff and some people spent all day sitting in the same chair, including when they ate their meals.

We observed one person sitting in the same seat throughout the day who told us they would like to have an electric wheelchair but had been told the corridors in the home are too narrow to get around. The person also told us a friend used to take them to the pub but they had not visited for some time and they really missed going. This person became distressed whilst we were talking to them and we saw they became upset at other times during the day but during our observations we did not see a member of staff try to support the person to meet their needs.

With another person, we saw that staff failed to observe the triggers detailed in a behaviour management plan for a person living with dementia. The plan identified loud noise as a trigger for the person to become agitated. We observed the person sitting in the lounge where music was playing loudly. Staff did not monitor this person and sat in the adjoining dining room where they could not observe them get out of the chair onto the floor. We were able to see this from where we were sitting and had to speak to staff to get them to go and help the person.

One person told us that they had only had one bath since the end of December and that they would like to have one more frequently. Staff told us and we saw that the records were not up to date and did not detail whether people had declined to have a bath if offered. The manager told us that they had recognised that this was an issue and a new member of staff was due to start to ensure people's needs and preferences were met.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints procedure displayed in the entrance hall and people we spoke to could identify someone they would talk to if they were unhappy about anything, which included staff, management and their family. However, we found gaps in the recording of complaints, for example we saw that a complaint made to the home in June 2014 had been recorded but there was no evidence of an investigation. This meant that people's concerns were not always listened to and action taken to make any necessary improvements.

Some staff we spoke with were knowledgeable about the people in the home and they used the information in their care plans to engage people in conversation or an activity. For example, we saw one member of staff bring a harmonica for a person as their family told staff they liked to play one.

Inadequate

Is the service well-led?

Our findings

A requirement of the service's registration is that they have a registered manager. There was no registered manager in post at the time of our inspection and we are currently in the process of removing the names of two former registered managers. The provider had recruited a new manager, who had only been working at the service for just over a month on the day we inspected. The manager told us that they would be applying to become the registered manager at the service. Staff told us that the registered provider was involved at the home and visited regularly. One member of staff told us, The senior carer held the fort after the manager left but morale was low and staff had left." The provider did not contact us to let us know that the manager had left and what steps they were taking to recruit a new manager and had failed to comply with a condition of registration.

The manager told us that they believed the service was incorrectly registered to accommodate 21 people and the provider had made an application to vary this. Under the terms of the home's registration, the provider must only accommodate a maximum of 21 people . At the time of our inspection 22 people were living at the service. Following the inspection, the provider submitted an application to vary the registration to accommodate 26 people. The provider would have had the opportunity to challenge the terms of the registration at the time the application was granted. Our records show that they did not do so and would therefore have been fully aware that they could only accept 21 people. They had not contacted us to discuss their plans before accepting additional people.

This is a breach of Section 33 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we inspected the service in April 2013, we found the provider was not meeting the standards required for assessing and monitoring the quality of service provision and this had a moderate impact on the people that used the service. When we returned in October 2013 we found that they had made improvements but at this inspection we found that these improvements had not been sustained.

The provider had not carried out any checks to assure themselves that the quality of the service was being maintained in the absence of the registered manager.

There were no audits in place to monitor the quality of care in the home, such as care plan entries or medication chart entries to monitor if these were accurate and appropriately written. The manager told us she would be starting monthly audits and showed us templates they would be using.

We found the monitoring of people at risk of poor nutrition was not well managed. Two of the care plans we looked at included dietary assessments for people who needed encouragement to eat to maintain their weight. This information had been passed to the kitchen but the cook told us there was no system in place to inform them of any changes. They told us, "We rely on the carers telling us". We found gaps in the recording of weights and no action had been taken to address one person's weight loss.

We found the administration of medicines was not well managed. People received their prescribed medicines and stocks were stored safely but staff did not routinely record the opening and expiry dates of some medicines, which meant that people could be at risk of receiving out of date medicines. The manager told us that night staff were not trained to administer medicines and if pain relief was required after 8pm, there was no suitable system in place to ensure people who used the service would receive pain relieving medicines when needed.

We saw that there was a system for recording accidents and incidents at the home. However, there were records missing and investigations were not recorded in full. For example where accidents had occurred we did not see any action plans or steps that should be taken to minimise the risks in future. There was no analysis of trends, for example if falls were happening when staffing levels were lower. This meant the provider did not have a system in place to identify how further repeated accidents or incidents might be avoided.

The provider did not have a system in place to monitor trends and learn from complaints to make improvements to the service where needed.

The manager told us there were no arrangements in place to ask people for their comments on the quality of care and if they would like to see any changes but they were considering the introduction of a dignity champion, who would work with people living at the home to improve the way that services are organised and delivered.

Inadequate

Is the service well-led?

This was a breach of Regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who we spoke with did not know who the manager was but when we told one person they said, "I've seen them [the manager] directing the staff". We saw that the manager knew people's needs and had positive relationships with the care staff. Staff we spoke with told us the manager was supportive and since coming to work at the service had implemented staff meetings where they had felt able to give their opinions, for example about staffing levels. During the inspection we saw that refurbishment works were ongoing at the service. The manager told us that the provider had allocated the resources to make improvements for people using the service.

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 provider was not acting in accordance with the Mental Capacity Act 2005.** **Regulation 11 (1)-(3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider was not ensuring service users needs were met or making reasonable adjustments to enable the service user to receive their care and treatment.** **Regulation 9 (3)(b)-(h)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Section 33 HSCA Failure to comply with a condition **We found the provider failed to comply with the conditions of their registration.** **We found the provider was operating without a registered manager.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have effective systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.** **Regulation 17 (1)-(2)-(b)**