Dr P & Mrs H Willis M Fazal & M Fazal

Bearnett House

Inspection report

Stourbridge Road
Wolverhampton
West Midlands
WV4 5NN

Tel: 01902895443
Website: www.bearnetthouse.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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 2 and 9 October 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. The home 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.

At the time of our inspection on 2 October 2018, 12 people were using the service. There were 10 people using the service on the 9 October 2018.

We have previously taken enforcement action against this home and there are currently conditions on their registration in place and people cannot be admitted into the home without the written permission of the CQC. After our visits on both 2 and 9 October 2018 we wrote to the provider to seek reassurances about peoples' safety. We did not receive the reassurances we requested.

There is not a registered manager in place and has not been since January 2017. 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.

At this inspection people were 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 falls occurred action was not taken to reduce the risk of reoccurrence and this resulted in a repetition of falls for people.

Staff demonstrated an understanding of safeguarding however we could not be assured all incidents had been fully considered or investigated to ensure people were protected from potential harm. There were not always suitably trained staff available who could administer medicines for people. People did not always receive support to eat or drink and were at risk of dehydration. When people had lost weight, action had not always been taken. People were not referred to health professionals for support when concerns were noted.

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 previous inspections.

Staff were kind in their approach however interactions were often task focused. People's cultural or dementia needs were not always fully considered. Staff received training however we could not be assured their knowledge in these areas was checked.

People's privacy was considered. People and relatives were happy with the staff and were free to visit anytime. The home was clean and decorated to consider people's preferences however was unsuitable for people living with dementia. 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.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.
Risks to people were not always managed in a safe way. When incidents or accidents occurred within the home they were not always investigated or reviewed to mitigate further risk. People were not always protected from potential harm or concerns investigated or reported when needed. People did not always receive support when needed as there were not always staff available who could administer medicines. The provider was not using information so that lessons could be learnt within the home. The provider ensured staff suitability to work within the home.

Is the service effective?

Inadequate

The service was not effective.
Capacity assessments were not always in place and there was no evidence decisions were made in people's best interests. When people's liberty was restricted, this had not always been considered. We could not be sure the training staff received enabled them to support people as needed as staff competency wasn't always checked. People did not always receive enough fluid or support at mealtimes. Referrals to health professionals were not always made when needed.

Is the service caring?

Requires Improvement

The service was not always caring.
People were not always treated in a kind caring and dignified way as staff did not always have time to spend with people.
People were happy with the care staff that supported them.
People were offered verbal choices as to how to spend their day.
People were encouraged to maintain relationships that were important to them.

Is the service responsive?

Inadequate

The service was not always responsive.
People's care was not assessed or reviewed to ensure it was relevant to their needs. People's communication needs had not been fully considered. People did not always have the opportunity to participate in activities that were of interest to

them. People's cultural needs were not always considered. People knew how to complain.

Is the service well-led?

Inadequate

The service is not well led
The providers remains in breach of regulations and have not made the necessary improvements needed to comply. The provider had not notified us about all significant events within the home. Audits were not driving improvements. There is no registered manager in post and this had led to inconsistent care. 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 2 and 9 October 2018 and was unannounced. The inspection visits were carried out by two inspectors, an inspection manager 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 care service.

We checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information that we had received from the public. A notification is information about events that by law the registered persons should tell us about. 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. Since our last inspection we have continued to receive information of concern about the home from member of the public and other professionals. We used this information to formulate our inspection plan

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 two people who used the service, three relatives or visitors, and five members of care staff. We also spoke with the manager, two of the partners and two of the partners representatives. 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 six 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 recruitment procedures and actions plan that were in place.

Inadequate

Is the service safe?

Our findings

At our last inspection we found risks to people were not always managed in a safe way. At this inspection we found there was a continued breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. The provider has now been in breach of Regulation 12 since our first comprehensive inspection in October 2015. We also saw staff were not always deployed to meet people's needs. We could not be assured all safeguarding concerns were reported appropriately. At our last inspection safe was rated as inadequate. At this inspection we found the provider had not made improvements and the rating remains inadequate.

Risks to people were not managed in a safe way. When people were at risk of falls the guidance in place to keep people safe was not always followed. For example, one person was identified as being at 'high risk of falls'. Staff told us and records confirmed this person was to be supervised at all times when in communal areas to reduce the risk of this person falling. We reviewed the incident and accident forms relating to this person and found in both August and September 2018 this person had unwitnessed falls in communal areas, meaning they had not been supervised as needed. Following the second incident, no risk assessment, person-centred care plan or falls risk assessment tool had been updated to reflect this fall, and no action had been taken to ensure the person was safe. The repetition of falls for this person demonstrated risks were not being monitored or mitigated. We had raised concerns about this person at our previous inspections and have previously taken enforcement action in relation to this.

Furthermore, during our visit on 2 October 2018, we observed on three occasions this person was unsupervised in communal areas. We have raised concerns about unsupervised communal areas with the provider since our inspection in December 2016 and no improvements had been made.

When people used equipment to keep them safe it was not always checked to ensure it was working or in the correct position. We saw an incident form had been completed in September 2018 and it was documented that a person had fallen. The incident noted that a sensor designed to alert staff if the person moved or fell was not in the right position so it could not help keep the person safe. Following this we did not see any action had been taken to ensure that the sensor was in the correct position. There was no documentation in place to confirm checks were completed to ensure the sensor was in the correct position or in working order. Staff confirmed they did not check this sensor. During our visit on 2 October 2018 we checked this sensor and it was not in range of the bed, as required. When we moved in front of the sensor no alert was sent to staff and we were not assured it was switched on or working. Staff were unable to confirm to us if this was in working order. We also raised this as a concern with the provider at our last inspection.

We reviewed other incident and accident forms and found when other people had fallen action had not always been taken. For example, we found another person had an unwitnessed fall in their bedroom. There was no risk assessment in place in relation to falls and how to mitigate ongoing risk and staff confirmed this to us.

We saw documented in an incident form in August and again in September 2018, another person had fallen

whilst transferring between chairs. After the first incident it was documented under 'action taken' that the person should remain in their wheelchair during mealtimes. After the second incident, we saw documented under 'action taken' that further consideration needed to be given as to how to transfer the person safely by staff and the manager. Staff confirmed no further action had been taken following this. We checked the records for this person and saw they had not been updated. The care plan in place stated this person should use a 'rollator frame' to transfer. We did not see this used during our inspection and staff confirmed this person no longer used this. No referral had been made to other professionals such as a physiotherapist or an occupational therapist for advice. This meant the provider had not taken action to ensure this person was transferred in a safe way, placing them at risk of injury.

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

There were not always trained staff available to administer medicines to people, and there were no systems in place to manage this. The manager told us during the night shift there were not always staff available who could administer medicines to people. The manager told us afternoon care staff would stay after their afternoon shift had finished to administer people's evening medicine. They told us this was until approximately 10pm. The morning staff would then be available at 7am. We looked at medicine administration records (MAR) and saw people were prescribed as required medicines over a 24 hours period, this included pain relief. The manager confirmed there were no procedures in place advising staff what they needed to do if people required medicines during this time. Staff we spoke with who had completed night shifts told us if people required medicines during the night then they would have to wait until staff arrived at 7am to administer these. This meant the provider had not ensured there were suitably trained staff to administer medicines to people which could leave people at unnecessary risk of being left in pain or experiencing symptoms of their health condition.

We received mixed views about staffing in the home. One person living at the home told us, "Yes there are quite enough staff I would say. I have not had any problems at all since I have been here". A relative said, "I would say that there are enough staff here at the moment for the number of residents they have. Should they take more in then they will need to get more staff to cover". During our inspection we saw that staff were busy and interactions with people was often task focused; for example, when people needed support with personal care. We observed in the communal area there were times where staff were not present, as required. This was as staff were offering support to other people. Staff told us they would benefit from more staff. One staff member said, "It's better now we have less people. The concern is there are only three staff on each shift. Some people need two staff to support and if people are up someone has to be in the lounge. It means that if someone else needs us no one can respond". This meant there was not always enough staff deployed to meet peoples' assessed needs.

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

We saw there were procedures in place in relation to safeguarding. However, the provider had not always reported safeguarding concerns to the local authority, as the lead agency for investigating safeguarding concerns, when needed. For example, an incident had occurred within the home, another person had raised this concern with staff working within the home, who had subsequently raised this with the providers. No action had been taken and this incident had not been investigated or recorded. The staff member had then reported this to us (the CQC). We then raised this as a safeguarding concern with the local authority, who investigated the concern. We also found other incidents had not been reported by the home as required, for example the district nurse team had raised a safeguarding concern about an unknown skin tear to a person.

Furthermore, when incidents had been unwitnessed the provider had not conducted an investigation to consider how these may have occurred. For example, one person had unexplained bruising. Staff had recorded this on a body map and no further action had been considered. This meant people were not always protected from potential harm. When risks and incidents had occurred within the home the provider had not used this information so that lessons could be learnt and improvements made for people.

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

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. The food standards agency is responsible for protecting public health in relation to food. However, we could not be assured all aspects of infection control were considered within the home as no audits or monitoring in this area were taking place. This meant concerns may not always be identified and remedied which left people at risk in relation to cross infection.

At our previous inspections we have found the provider has not had a suitable recruitment process in place. At this inspection there had been no new care staff. We therefore reviewed the recruitment records for the manager and found the necessary checks had been completed to ensure their suitability to work within the home.

Inadequate

Is the service effective?

Our findings

At our last inspection we found the provider was not meeting the requirements of The Mental Capacity Act 2005 (MCA) to ensure people's rights were upheld. Staff were also not applying the principles of the act to ensure they acted in people's best interests. At this inspection we found there was a continued breach of Regulation 11 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. The provider has now been in breach of this regulation since our first comprehensive inspection in October 2015. We also found the provider did not always follow health professional's advice to keep people well. At our last inspection effective was rated as requires improvement. The provider has not made improvements and the support people received has deteriorated and it is now rated inadequate.

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).

When people had restrictions placed upon them there were not always decision-specific capacity assessments in place. One person lacked capacity to make decisions for themselves. There was no individual capacity assessment in relation to the night alert sensor they were using and no evidence the decision to use this had been made in their best interests. This meant the sensor was put into place which restricted the person, without following the principles of the MCA.

The manager told us another person had a deprivation of liberty safeguarding (DoLS) authorisation in place. When we checked this authorisation, it had expired in January 2018. The manager was not aware of this and a new application had not been submitted. This meant this person was unlawfully being restricted as no legal safeguards were in place. We saw, and the manager confirmed, there was no system or tracker in place identifying which people had DoLS in place or information as to when they expired. As we saw this person had expired this meant the system that was in place was not effective.

We reviewed the DoLS that had expired for this person and found there were conditions on it. There was specific information around activities that should take place for this person and should be documented when they had occurred. There was no documentation of these activities in place and when we discussed these with staff and the manager they were unaware of these. This meant the legal conditions put in place to protect the person were not being followed.

We found that not all staff had received training on the MCA to equip them with the skills and knowledge to support people safely and effectively. Staff we spoke with could not demonstrate a sound understanding of the MCA. This showed us staff did not have the knowledge and skills needed to ensure that principles of the MCA were followed to ensure people consented to their care and treatment.

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

People did not always receive enough to eat or drink. We saw people were offered food and drinks, however we did not always see staff encouraging people to eat or drink more. People were also not always supported to eat and drink when needed. For example, at lunch time during the visit on the 2 October 2018 we observed two people sat in the lounge independently. A staff member gave the people their meal however did not offer any support. They were not supported or offered support at any point during their meal. We observed one person was moving their meal around their plate and only ate several mouthfuls. Over 20 minutes later a staff member brought both the people a drink and again they did not offer any support to the people to eat their meal or with their drink. We saw one person ate approximately ¾ of their meal before staff took it away. We did not see them drink their drink. We checked records for this person and we saw documented, 'drinks well and staff support'. We also saw documented in a letter following a hospital appointment that concerns had been raised about this person's 'drinking levels'. We spoke with a representative for the provider and the home manager who could not provide us with any more information about action that had been taken. They were unaware of the letter.

We therefore reviewed fluid balance charts that were completed for this person from 24 September to 1 October 2018 and found the person had consumed between 600-1080mls per day during this time. It was documented throughout the fluid balance charts that this person had refused drinks. There was no care plan or risk assessment in place for this. As there was no daily recommended amount recorded we could not be assured this person drank enough and remained at risk of dehydration. The charts that were completed were not being checked by anyone in the home. After our visit on the 2 October 2018 we wrote to the provider and asked them to take immediate action to keep this person safe. We carried out a further visit on 9 October 2018 and found the provider had not taken the action they had told us they had taken. The provider had introduced a daily target for this person, however this person had not always reached this and no action had been taken as result, which meant the person remained at risk of dehydration.

At our visit on 9 October 2018 we saw another person had a fluid balance chart in place, there was no reference in this person's care file as to why this was required. We reviewed the fluid balance chart and could not be assured this person was receiving adequate fluids or if further support was required. As there was no auditing of fluid charts taking place for people living at Bearnett House, this meant that the quality and effectiveness of these records had not been reviewed and action had not been taken to ensure people were receiving adequate fluids and remained at risk of dehydration.

This is a breach of Regulation 14 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Due to previous enforcement action we have taken the provider had a condition on their registration that they could not admit or readmit people into the home without the written permission of the CQC. Prior to our inspection we received information following a safeguarding concern that was being investigated within the home. Throughout this process it was identified a person had been admitted to hospital, the provider requested our written agreement for this person to return to the home. They provided us with an assessment that had been completed and we agreed this based on the information they had provided to us. However, the investigation identified this person was discharged from hospital a week after they were assessed, during this time the person deteriorated, their needs changed and they were not re-assessed as they should have been. The provider had not ensured this person's care plans and risks assessments were updated or reflective of this person's needs. This resulted in a safeguarding regarding neglect of the person being substantiated. This meant people's needs were not always assessed and plans were not put in place

to meet their needs.

People were not always referred to health professionals as needed. For example, as reported upon in responsive, when people had lost weight there was no evidence this had been followed up with the GP or any other professional. This left people at risk of unintentionally losing weight and action not being taken to protect peoples' health and wellbeing. We also found a person had not been referred to a physiotherapist or occupational therapist. This left the person at risk of falling or not being supported appropriately with their mobility. Another person continued to fall and there was no evidence they had been referred to the falls team and there was no documentation in place to support what action or advice had been taken. Health professionals raised concerns to us about the home and the provider about the lack of referrals they received.

After our visit on the 2 October 2018 we wrote to the provider and asked them to take immediate action to keep these people safe. We carried out a further visit on 9 October 2018 and found the provider had not still not referred these people to health professionals. This meant the provider had failed to ensure people's health and well-being were being protected, which left people at continued risk.

At our last inspection, although staff received training, staff's competency was not always checked and we could not be assured the training they had was effective. At this inspection we found the same concerns as the previous inspection. Some staff told us the training they received helped them support people, however we could not be assured how effective the training was. For example, staff told us they had received MCA and DoLS training, however some staff did not demonstrate to us an understanding in this area. Safeguarding incidents were not always being identified and action was not always taken. This indicated training had not always been effective. The provider was checking staff competencies in some areas, for example in the management of medicines. The manager told us senior care staff were completing these competencies for staff. They confirmed they had not received any additional training in this area and some of their competencies had not been checked. We also found this concern at our last inspection. This again meant we could not be sure competency checks were being completed correctly.

The home was decorated in accordance with people's preferences, however it was not suitable for people living with dementia as there was not appropriate signage for people. People's personal belongings were in their rooms, including photographs of people who were important to them. There was a garden area that was suitable for people to use.

Requires Improvement

Is the service caring?

Our findings

People and their relatives were happy with the staff that supported them, however staff did not always feel they had time to spend with people and we observed this to be the case. One staff member said, "We are rushed with just the three staff." We observed there were long periods where staff did not offer support to people in communal areas or when people were in their rooms. As staff were rushed they did not always have time to spend with people or explain what they were doing. At lunchtime as staff were supporting all the people into the dining room it meant some people had to wait over 35 minutes for staff to be available to offer support to them and other people did not receive the support they needed. This meant staff did not have time to treat people in a kind and caring way.

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 their meal but there were no pictures or prompts used to support these people to make their choices. We did not see any signage or adaptations that would offer appropriate support for people living with dementia. For example, all bedroom doors were the same; there were no pictures or personal objects that may help people identify their rooms. There was no signage throughout the home guiding people to communal areas such as the bathrooms. We also raised this as a concern during our last inspection. This meant there was a risk people would not be able to be as independent as possible and could lead to confusion.

People's privacy and dignity was not always promoted. A relative commented, "Oh yes it certainly is. They always close the door when taking my relation to the toilet and washing them. No issues at all with this". Staff gave examples of how they treated people with respect and promoted their privacy and dignity. However, when people were supported to use specialist equipment we saw people's clothes were not always adjusted by staff so their dignity remained.

People told us they made verbal choices about their day. One person said, "I always like to stay in my room and have my breakfast. I do that every morning and then I come into the communal rooms later on". Staff gave us examples of how they supported people to make choices. One staff member said, "We ask people where we can so we know what they like." Some care plans we reviewed reflected people's choices as well as likes and dislikes. However, it was unclear from records for other people how they made choices and how their likes and dislikes had been considered.

People and relatives spoke positively about the staff and the support they received from them. One person said, "Very caring indeed. I like it here very much. It's the friendliness of the staff that make it so special for me. They are always asking how I am". A relative told us, "The staff are magnificent. They are all friendly, even any newer ones who get to know [person] very quickly. Nothing is too much trouble for them".

Relatives and visitors we spoke with told us the staff were welcoming and they could visit anytime. We saw relatives and friends visited throughout the day and they were welcomed by staff.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found people did not always receive care that was responsive to their needs and people's cultural needs were not considered. People were not always offered the opportunity to participate in activities they enjoyed and felt there could be more to stimulate them. At this inspection we found there was a continued breach of Regulation 9 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. Complaints were not responded to in line with the providers procedures. This was a breach of Regulation 16 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found there was no longer a breach of Regulation 16

People did not always receive care that was responsive to their needs. At our visit on 2 October 2018 we saw documented in one person's care plan they were to be weighed monthly due to their nutritional risks. We reviewed the weight chart for this person and saw they had continued to lose weight since January 2018. There was no evidence to show what action had been taken following this weight loss. The representative for the partnership and the home manager could not provide us with any more information to show that action had been taken. There was no risk assessment in place identifying this weight loss or guidance in place for staff to follow. There was no evidence this had been followed up with the GP or any other health professional. In addition, this person had not been weighted since August 2018. Furthermore, we did not see staff encouraging this person at mealtimes or offering support to eat and drink.

After our visit on the 2 October 2018 we wrote to the provider and asked them to take immediate action to keep this person safe. We carried out a further visit on 9 October 2018. At this visit we found the person had been weighed and had lost even more weight. The provider had still not taken any action which left the person at continued risk to their health and well-being.

At our visit on the 9 October 2018 we reviewed a weight chart for a second person and found they had also lost weight in 2018. Despite also being on monthly weights their last recorded weight was in August 2018. There was no evidence to show what action had been taken following this weight loss. Staff and the manager confirmed no action had been taken. There was no risk assessment in place identifying this weight loss or guidance in place for staff to follow.

People's cultural needs had not been considered. At our last inspection the provider confirmed this was not something they assessed or considered for people living within the home. At this inspection we found no changes had been made or considered. This left people at risk of experiencing inconsistent care or care that did not reflect their cultural needs.

At our last inspection 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 or sensory loss are given information in a way they can understand. At the last inspection we looked at one person's file which stated they had hearing difficulties. A communication care plan was in place however it did not detail any further interventions about how they could be supported to receive information, for example photographs or pictures. The advice recorded was that staff

speak loudly. At this inspection we reviewed this person communication plan and it remained the same.

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

At our last inspection we found people did not always have the opportunity to participate in activities they enjoyed or that people received stimulation to keep them occupied. At this inspection we found some improvements had been made however this was due to family and friends. One relative told us, "If I had just one concern with the home it would be the lack of activities. About 15 months they did have a lady doing them but she went and was not replaced. The carers do things now but I appreciate many here couldn't probably join in but I believe the manager here now is looking into activities for them." Since our last inspection relatives and friends had set up a group called 'Friends of Bearnett House'. They held activities such as a BBQ and coffee mornings and people had the opportunity to attend. People spoke positively about these events and told us this was something they enjoyed. However, we checked activity records on a day to day basis and the last activity was documented as being carried out on 22 August 2018. During our inspection we saw a game of cards being carried out for a short period of time during the morning of our inspection. The provider did not have an activity coordinator in place and the manager told us this was an area that needed improving.

At our last inspection we found complaints were not responded to in line with the provider's procedure. We found no complaints had been made since our last inspection, therefore there was no information for us to review. People we spoke with told us they had not made a complaint but would talk with staff if they were concerned. As we did not speak with anyone who had made a complaint since our last inspection we could not consider this information.

The provider was not supporting people with their 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 previous inspections we found there was a lack of systems in place to monitor and improve the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. At this inspection we found the provider was in continued breach of this regulation. The provider has now been in Breach of Regulation 17 since our first comprehensive inspection in October 2015. At our last inspection well led was rated as inadequate. The provider has failed to make improvements and the rating remains inadequate.

We have inspected this location on seven separate occasions since October 2015. During this time Bearnett House has been rated as either requires improvement or inadequate. Despite meeting with the providers and being provided with action plans we have found that the provider has failed to make the necessary improvements and failed to comply with the regulations. This meant the provider had failed to ensure people received safe and consistent care which protected peoples' health and well-being. We have previously taken enforcement action against this home and there is currently a condition on the provider's registration that people cannot be admitted into the home without the written permission of the CQC. We have also imposed other positive conditions on the provider's registration.

Furthermore, when improvements have previously been made these were not sustained. For example, at the inspection in January 2017 the provider had made improvements in relation to staffing and they were no longer in breach of regulation 18 of the Health and Social Care Act 2008. However, at this inspection the provider had not sustained these improvements and the they were again in breach of this regulation. In addition to this, since our first inspection in October 2015 the provider has remained in breach of regulation 11,12 and 17 of the Health and Social Care Act 2008 and has not been able to make the necessary improvements to comply with the regulations. This demonstrated the management systems in place were not driving improvements and were inconsistent.

When incidents or accidents had occurred we did not see action was taken to mitigate further risks, or that this information was used to make improvements for the people living at Bearnett House. We saw and the manager confirmed, that when an incident occurred there was no information available so that lessons could be learnt or improvements made. This resulted in the same incidents reoccurring for people which left people at risk. The care plan or risk assessments had not been updated or reviewed after the falls had occurred, and a referral to an appropriate professional for support had not been considered. We have raised this as a concern since our first inspection in October 2015.

We could not be assured all incidents and accidents were reported and recorded so that these could be fully considered. For example, when safeguarding incidents had been identified, falls and other incidents had occurred within the home that had not been recorded and action taken and the provider was aware of these. This meant the provider had failed to maintain an accurate contemporaneous record in respect of incidents that had occurred. They had also not considered their responsibility under duty of candour.

We saw a weekly medicines audit had been completed. This had identified errors within the home, such as

incorrect stock level and medicines that had not been signed for. We saw documented under 'action' it stated, 'manager informed'. We saw no further action had been documented and the manager confirmed to us these had not been followed up. This meant when concerns around the management of medicines had been identified no action had been taken.

We found no evidence of audits taking place in the other areas or oversight of the quality and safety of the service. For example, aspects of care such as daily records or monitoring charts including fluids and weights were not being overseen. We found concerns in these areas during our inspection.

We saw that a new survey had been introduced to capture the views of people who used the service. Only one person had the opportunity to complete this and where areas of improvement had been identified we did not see what action had been taken to make the improvement.

Although the provider was notifying us of some significant events that had occurred within the home such as deaths, we had not received notification for the incidents that we refer to throughout this report. This meant all significant events that occurred within the home were not always reported to us so we could ensure appropriate action had been taken and people were safe.

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

There was no registered manager in post and one has not been registered with us since January 2017. There was an acting manager in post at the time of our inspection. There have been five acting managers in post since the last registered manager left. The changes in the manager at the home had led to inconsistences. For example, at this inspection we found the care plans has changed since the last inspection. The care plans lacked detail about the support people needed. Staff told us they had raised this as a concern with the manager. We also saw some of the systems that had previously been put in place to keep people safe were no longer completed. For example, checks on equipment such as alert sensors were no longer being completed. We wrote to the provider about our serious concerns after our first visit on 2 October 2018 they recognise this was an area of improvement and told us action had been taken. However, when we checked this on 9 October 2018 we found no improvements had been made.

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 their 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 9 HSCA RA Regulations 2014 Person-centred care People's care was not assessed or reviewed to ensure it was relevant to their needs. People's communication needs had not been fully considered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Capacity assessments were not always in place and there was no evidence decisions were made in people's best interest. When people were being restricted this had not always been considered.

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 managed in a safe way. When incidents or accidents occurred within the home they were not always investigated or reviewed to mitigate further risk.

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 People were not always protected from potential harm or concerns investigated or

reported when needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not always receive enough fluid or support at mealtimes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers remains in breach of regulations and have not made the necessary improvements needed to comply. The provider had not notified us about all significant events within the home. Audits were not driving improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People did not always receive support when needed as there was not always staff available who could administer medicines.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Capacity assessments were not always in place and there was no evidence decisions were made in people's best interest. When people were being restricted this had not always been considered.

The enforcement action we took:

Proposal to cancel the providers registration.

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 managed in a safe way. When incidents or accidents occurred within the home they were not always investigated or reviewed to mitigate further risk.

The enforcement action we took:

Proposal to cancel the providers registration

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 managed in a safe way. When incidents or accidents occurred within the home they were not always investigated or reviewed to mitigate further risk.

The enforcement action we took:

Urgent conditions imposed on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers remains in breach of regulations and have not made the necessary improvements needed to comply. The provider had not notified

	us about all significant events within the home. Audits were not driving improvements.

The enforcement action we took:

Proposal to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers remains in breach of regulations and have not made the necessary improvements needed to comply. The provider had not notified us about all significant events within the home. Audits were not driving improvements.

The enforcement action we took:

Urgent conditions imposed on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People did not always receive support when needed as there was not always staff available who could administer medicines.

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People did not always receive support when needed as there was not always staff available who could administer medicines

The enforcement action we took:

urgent conditions imposed on the providers registration