Alexander Park Homes Limited

The Bill House

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?	**Requires Improvement**

Summary of findings

Overall summary

The Bill House is registered to provide accommodation for up to 38 people, some of whom are living with dementia and who need support with their personal care needs. On the day of the inspection 35 people were living at the service, one person was in hospital. The Bill House is a large property with accommodation over two floors. There were communal lounges, dining areas and access to a garden.

We carried out the previous comprehensive inspection on 25 January 2016. The overall rating at this inspection was Good. There was a breach of regulation related to safe care and moving and handling techniques. Following the inspection, the provider sent us an action plan, telling us staff would receive training and supervision in this area and observations of moving and handling procedures would be commenced. During this inspection, we had no concerns about how people were supported to move by staff however, we found concerns related to infection control, aspects of safety within the service, and aspects of medicine management. We also had concerns related to staff following the Mental Capacity Act, staff training, care planning and record keeping, respecting people's dignity and the governance processes in place at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their relatives told us staff were caring and kind. Most people told us they liked living at the service and were happy. Professional feedback was positive about the registered manager, staff and service provided. Staff demonstrated kindness and compassion for people through their conversations and interactions we observed. However, we saw people's dignity was not always promoted and they were not always actively involved in making choices and decisions about their care and treatment.

People were protected from abuse because staff understood what action to take if they were concerned someone was being abused or mistreated. Relatives confirmed they felt their loved ones were safe.

Risks associated with people's care and living environment were not always effectively managed to ensure people's freedom was promoted. We were concerned that communal bathrooms were locked and people did not have access or keys to their bedrooms. We found some windows did not have restrictors in place and a small kitchenette was left unstaffed at times which could pose a risk. We also had concerns that at the time of the inspection there was no record of external visitors to the service. This meant in the event of a fire, it would have been unknown who was in the building.

We found areas of the home were not clean and best practice in relation to infection control was not followed.

People and their relatives were encouraged to be part of the care planning process and to attend or contribute to discussions about care where possible. However, these discussions were not always well recorded or reflected in people's care records. Some support plans were out of date so did not reflect people's current needs. We also found end of life care plans required developing to reflect people's needs at this time in their life.

People were supported by consistent staff to help meet their needs in the way they preferred. However, it was not always clear if people were given a choice of male or female staff when they required support with personal care.

The registered manager and provider wanted to ensure the right staff were employed, so recruitment practices were safe and ensured that checks had been undertaken.

People's medicines were mostly well managed. However, some people had medicines without their knowledge and the processes which are required to be followed to administer medicines in this way were not always followed.

People received care from staff who had undertaken the provider's essential training programme, but training to meet people's specific health needs for example diabetes and epilepsy were not in place at the time of the inspection. Not all staff had undertaken dementia training.

People's human rights were not always protected because the registered manager and staff did not have a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. We found the systems in place to record people's capacity and decisions made in relation to care and treatment required improvement.

People's nutritional needs were met because staff followed people's support plans to make sure people were eating and drinking enough and potential risks were known. However, an overview of people's total fluid intake goal was absent and at the inspection there was a lack of choice available and how to support the nutritional needs of people living with dementia. People were supported to access health care professionals to maintain their health and wellbeing.

Policies and procedures across the service were being developed to ensure information was given to people in accessible formats when required but at the time of the inspection these were in there infancy. Staff adapted their communication methods dependent upon people's needs, for example using simple questions and information for people with cognitive difficulties and we were told information about the service was available in larger print for those people with visual impairments.

People and relatives felt comfortable raising any concerns and felt confident these would be addressed promptly. We were told people were asked for their views but the recording of these decisions was not apparent for example communal bathrooms being locked, access to bedrooms and involvement in menu discussions. Relatives felt welcome at the service and visiting was not restricted.

The service was led by the registered manager. They received support from the regional manager and provider. The quality assurance systems in place had not identified the areas of concern we found during the inspection however these were under review following inspection feedback. The registered manager and provider promoted the ethos of honesty and admitted when things had gone wrong.

We have made recommendations in relation to the environment and staff training.

We found four breaches of Regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected from the spread of infection, because safe practices were not followed to minimise any associated risks.

People were not always supported to have as much control and independence as possible. People's risks were not always well managed.

People were exposed to risks in relation to the environment and premises.

People had their medicines managed safely.

People were protected by safe recruitment practices and there were sufficient numbers of skilled and experienced staff to meet people's needs.

People were protected from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

People received support from staff who knew them well but staff required further training in some areas to meet people's specific health needs.

Staff had some understanding of the Mental Capacity Act. However, there was a risk people's rights were not protected because decisions specific capacity assessments were not completed. Choice and involvement in decision making was not always apparent.

People were cared for by staff that were well supported and had the opportunity to reflect on practice through supervision.

People's eating and drinking needs were known and supported but there was a lack of involvement and choice offered in meals. People's risks in relation to their food and fluid intake were not

always care planned.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always well supported to make decisions about their care. Some people could not access their bedrooms for privacy as they were kept locked and they did not have a key.

People were not always treated with dignity. People did not have the support they required to enable them to be as autonomous and independent as possible.

People and their relatives were positive about the service and the way staff treated the people they supported.

People were spoken to kindly by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personalised care and support. Care records did not always reflect people's needs and were not always up to date.

People's end of life preferences were not always known and recorded.

People were assessed to ensure the service could meet their needs. Equality and diversity was respected but not well evidenced. The accessible information standard required implanting for people who required information delivered or presented in a different format.

People knew how to make a complaint and raise any concerns. Complaints were thoroughly investigated and learned from. People and relatives had no concerns.

Is the service well-led?

Requires Improvement

The service was not well-led.

Some quality assurance systems were in place to drive improvement and raise standards of people's care. However, at the time of the inspection the systems in place had not ensured people's care in relation to the assessment of people's capacity, dignity, care and treatment needs, medicine management,

infection control and record keeping met current regulations.

People told us the registered manager was approachable.

The service worked in partnership with the local authority and primary care services.

The Bill 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.

The Bill House provides residential care to a maximum of 38 people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulated both the premises and the care provided, and both were looked at during the inspection.

This inspection took place on 10 and 11 January 2018. The first day of the inspection was unannounced. The first day of the inspection was carried out by one adult social care inspector, a bank inspector and an expert by experience. An Expert by Experience is a person who has experience of using or caring for someone who uses this type of service.

We reviewed the PIR which had been completed in November 2015, the provider had not been requested to update this since that time.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since their registration. A notification is information about important events, which the service is required to send us by law.

During our inspection we met with ten people who used the service and spoke with three visiting relatives for their views on the service. We reviewed people, relatives, staff and professional feedback during the inspection. We spoke with the registered manager, the deputy manager, and two care staff during the inspection. Following the inspection we spoke with the regional manager and one of the providers. An action plan was sent to the Commission addressing the areas discussed during inspection feedback.

We looked at six records which related to people's individual care needs, these included their care plans and their room records, which detailed how frequently people were repositioned if they were cared for in bed. We discussed staff recruitment processes with the registered manager, reviewed staff training and looked at

the quality assurance processes used to review the quality of the care provided. We reviewed policies and procedures, people and staff feedback and the processes in place to manage medicines. We discussed complaints, safeguarding and incidents which had occurred within the home over the past 12 months, with the registered manager.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in January 2016 we found people were not always supported to move in a safe way by staff. The provider sent us an action plan which advised staff training and supervision on moving and handling would be put in place. We found this had been actioned and the registered manager was observing staff practice. During this inspection we observed people were moved in a safe way and equipment such as walking frames and wheelchairs were used correctly.

People and relatives said the service was safe, however we found improvement was required in relation to infection control, aspects of medicine administration and the assessment of risk in relation to people and the environment.

Prior to the inspection we had received anonymous information about the cleanliness of the service and areas of the service smelling of urine. We found infection control measures were not sufficient to ensure all areas of the service remained clean and odour free. The lead for infection control was the registered manager who advised, "it is a work in progress".

There were malodours throughout the home. We found the chairs in the main lounge smelled of urine, were soiled with food debris, and two chairs were found with faeces on them. These were cleaned promptly when we brought this to the attention of staff. We spoke with the registered manager and regional manager about the furnishings in this room which did not support good infection control and could not be easily cleaned. Washable kylies were in use in the communal lounge, we were told by staff these were in place to protect chairs. We found these also smelled of urine and we spoke with the registered manager and regional manager about reviewing people's continence care and management to protect people's dignity. Following the inspection we received an action plan from the regional manager advising three chairs had been replaced and a plan for replacing the others was in place over the next 12 months.

One of the communal bathrooms was open on the second day of the inspection (at the time of the inspection these were usually kept locked). This room was used as a short term storage area for soiled and unclean laundry until staff had time to take it to the external laundry room. There were some use of raised trolleys but we also found red bags with soiled items on the floor (red bags contain soiled linen / clothing. Due to Health and Safety legislation, residential care home staff cannot come into contact with soiled bedding. Therefore by filling the red bags with bedding and then loading this directly into the washing machine helps to avoid this contact.). This meant the good practice guidelines for handling soiled laundry and reducing the risk of infection were not being followed. People would have been unable to access this bathroom to use the toilet or bath whilst it was used for storing soiled laundry and it smelled very strongly of urine. We raised our concerns with the registered manager about how this bathroom was being used. They were unaware that using the bathroom and managing the laundry in this way was not good infection control practice.

We discussed the cleaning routines with three of the cleaning staff. They had a set daily cleaning routine but no other routines or cleaning checklists in place, for example a rota of deep cleaning rooms. We asked when

the curtains in the main lounge had been cleaned as they had brown stains on. The registered manager informed us they had been cleaned but the stains had not come out. They advised new curtains were due to be purchased. The cleaning staff had one mop on each trolley with one mop bucket, and we observed the same mop was used to clean people's floor bedrooms and urine spillages. There was no overall cleaning schedule in place at the service which detailed daily, weekly, monthly and seasonal cleaning duties. There was no regular audit in place for cleanliness and infection control within the service. The lack of good infection control practices placed people and staff at risk of cross infection.

We looked at the laundry room. We saw that each person had their washing stored, washed and dried together. Soiled laundry was mixed with people's clothing and washed and dried together. We looked at the contents of the sacks and could see it was a mixture of people's clothing, towelling and linen. This represented a high risk of cross contamination.

We reviewed the home's infection control policy which had been updated in 2017 but did not reflect NICE (National Institute of Clinical Excellence) guidance. There were yellow sacks in place for the collection and disposal of clinical waste and weekly collections made by an external contractor. There were hand washing facilities, hand gel, aprons and gloves in place. This helped to protect staff from the risk of infection however, all communal bathrooms were locked and people did not have keys to access their own ensuite should they wish to wash their hands without staff intervention. Some people, due to their cognitive needs would not have been able to ask staff to open these bathrooms. Following the inspection an action plan was submitted advising changes to the laundry system and staff training in infection control.

During the inspection we noted that some windows across the service did not have restrictors in place. One person we spoke with told us they had fleeting thoughts of walking to the sea and drowning themselves. Their ground floor window opened fully and if they wanted to leave the building they would have been able to. One window, in the corridor opened onto the front, concrete courtyard. If a person tried to leave this may, injury may have been caused. Another upstairs window also had no safety mechanism in place to stop someone falling out. We brought this to the registered manager's attention and asked them to check and assess the risk of all windows. An action plan was submitted following the inspection advising all windows would be fitted with safety devices to protect people. We requested confirmation of this following the inspection.

One area of the service which staff called the Annexe had a kitchenette. On the first day of the inspection we observed there were periods of time when this area was not staffed. Whilst we were in the kitchenette which was accessible to all people at the service, one person came in. The kitchenette had an oven with waist high hob controls, a kettle and other items which if hot could cause injury. The provider had not assessed the risk of people being able to access this area without staff support. The registered manager told us this room was usually either staffed or locked.

People were supported with their medicines if they required, and had care plans in place which detailed the medicine they were prescribed. People, who were able to, confirmed they were supported with their medicines when they required them. Staff responsible for administering medicines received training and their competency was checked to ensure they were safe and followed the provider's medicine policy. However, care staff were preparing people's insulin without having received training in this area and one person was prescribed midazolam (a medicine prescribed for people who have epilepsy) but staff had not received training to administer this medicine either. The registered manager told us they did not realise staff required training. The regional manager and provider advised us staff training would be arranged. Following the inspection the action plan confirmed the district nurses would administer people's insulin until staff had received training and the local pharmacist was providing staff training in the administration of midazolam.

Records were in place in relation to specific medications, for example records were clear if medicines interacted with certain foods or if people had allergies and body maps were used to identify where skin creams were required.

We spoke with the registered manager about incorporating people's risks within the care plans. For example, two people's falls risk assessments had changed but care plans had not been updated to reflect these changes. Another person we met was at risk of choking, the service had asked for an assessment of their needs from the speech and language team on two occasions. Guidance was in place in people's room for staff supporting the person with meals which included ensuring they were sat upright and their care records stated they were on a blended diet. However, there were no individualised choking risk assessments in place or care plan to guide staff how to manage these potential risks. Following the inspection we were told these were now in place for those at risk. We also spoke with the registered manager and provider about greater detail being required in people's diabetic care plans to guide staff in the event the person was hypoglycaemic or hyperglycaemic. An action plan submitted following feedback incorporated staff training on diabetes and revising risk assessments and care plans in this area.

This is a breach of Regulation 12 of the Health and Social Care Act 2008.

People were supported by staff who managed some areas of risk effectively. People's safety was discussed in staff meetings and regular handovers. People's mobility, continence, skin care, weight and nutritional needs were monitored closely to ensure any change was acted upon promptly. Falls at the service were low and those at risk of continued falls had preventative plans in place which considered whether a referral to the falls team was required and any equipment people might need. We observed equipment such as wheelchairs, walking frames and other moving and handling aids were used safely and regularly serviced.

When we arrived at the service there was no signing in / out book at the service. The registered manager told us people at the home removed the book; but this meant in the event of a fire it would not be known who was in the building. We also noted fire doors were locked. Although staff had individual keys to open the fire exits, we requested West Sussex Fire Service review the home's fire risk assessment and door locks to ensure they met the required fire safety standards. Following the inspection the fire service confirmed they were satisfied with the fire safety risk assessment in place and locked fire doors. The registered manager told us staff had all received fire training and there were regular fire drills. Personal evacuation plans were in place. These were kept in the registered manager's office but would not have been easily accessible in the event of an emergency due to the layout of the building.

People were kept safe by staff who understood how to identify the signs of abuse and what action they would need to take if they witnessed or suspected that someone was being mistreated. This included an understanding of which external agencies they would need to alert. There was a safeguarding policy in place. We spoke to the registered manager about a misunderstanding they had with communication from the safeguarding team regarding what should be reported. It had been misunderstood that incidents between people which cause harm did not require reporting to the local authority safeguarding team. We clarified this during the inspection to ensure the local authority were informed in future.

Policies and regular feedback from people using the service, helped confirm people were protected from discrimination and ensured all people were treated equally. At the time of the inspection, equality and diversity policies were under review and being updated. Staff confirmed they had undergone training in this area. How to keep people safe was discussed in handovers and supervision and staff knew how to safeguard people and care for their property and belongings. Staff all confirmed they would not hesitate to raise any concerns.

People were supported by staff that were safely recruited. Checks on new staff were undertaken to ensure staff were safe to work with vulnerable people. Recruitment processes such as interviews helped the registered manager check the values and caring attitude of new staff.

People were kept safe by sufficient numbers of staff. People, who were able, confirmed their call bells were answered promptly when they required assistance. The staff team worked flexibly to provide cover for sickness and unforeseen events; this helped to provide continuity for people. Additional staff were on duty during the evening to support people with meals.

Staff understood what action to take in the event of an incident and followed internal procedures for reporting and documenting these. However, there wasn't a system in place to analyse incidents which may have occurred. This meant staff did not benefit from learning and possibly prevent a reoccurrence. Lessons were learned from previous events, for example the registered manager explained how improvements were made to skin care after people had previously developed skin damage. Training, education and discussion with staff on good practice had been held and we found the management of skin care to be robust and involve the specialist tissue viability nurses when required. The registered manager and the regional manager told us action was being taken to address these concerns.

Regular health and safety audits supported continual improvement. The home was well maintained by the maintenance man and external contractors to ensure electrical, gas and water checks were completed as required.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective.

At the last inspection in January 2016 this area was rated as Good with a note that there was inconsistency is assessing people's capacity in line with the Mental Capacity Act. At this inspection we found improvement was still required in this area.

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 for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and the least restrictive option available.

The registered manager had some understanding of the processes required to ensure decisions were made in the best interests of people. Throughout the inspection we heard staff regularly seeking people's consent to care and providing explanations for interventions. People, who were able to, confirmed staff asked for their consent when providing personal care. However, there was a lack of individual, decision specific mental capacity assessments. For example one person was nursed in bed and required bed rails for their safety. There was no evidence that this person's capacity to make this decision had been assessed or that it had been discussed with those people involved in their care. We found that each evening staff turned on a sensor to monitor people's movement at night. However, they had not followed the principles of the mental capacity act; we found there was no mental capacity assessment in place to show this was in the person's best interest or the least restrictive way of keeping them safe. We found people had not been individually involved or assessed in relation to decisions about the areas of the service we found locked. For example, people who lived at the home did not have access to communal bathrooms or their own key to their room. Staff explained this was for people's safety and in people's best interest but records did not support individual assessments being undertaken to establish if this level of surveillance was required.

Another person told us that staff held their cigarettes in the office. There was no evidence in the person's care records that this decision had been discussed and agreed with the person. Staff advised this was in place to support the person manage the money they spent on cigarettes.

We found that four people lacked the ability to make decisions about their medicines and they were being given their medicine "covertly" (without their knowledge). Although this decision had been agreed by their doctor there were no mental capacity assessments in place to show it was in people's best interests and no evidence of pharmacy involvement in the safe method of administration for their medicines.

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 procedure for this in care homes is called the Deprivation of Liberty Safeguards. Some people at the service were subject to these safeguards and other people had applications in progress with the local supervisory body. However, the service's recording of the

decision making process and the mental capacity assessment in relation to whether the person was capable of making a decision to remain of their own accord at the home was absent.

Following the inspection we spoke with the registered manager, regional manager and the owner of the service about these restrictions and the need to make individual assessments of people's capacity and review these restrictive care practices. They told us these restrictions were one of the reasons external professionals liked the service was because it kept people safe. They also submitted an action plan advising these areas would be addressed to ensure any constraints upon people's movement were appropriately assessed and the principles of the MCA were followed.

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

The Bill House was not purpose built; the environment had been adapted for people to mobilise safely. Handrails were available for people to move around the corridors safely. There were several communal areas of the service where people could have privacy with visitors or relax quietly. There was some signage in place to help orientate people but during the inspection we saw this caused confusion. For example there was signage to the bathrooms but then people could not access them. We also found some people who were lost and in need of guidance to find the lounge. Staff told us some people would go into other people's bedrooms which was why most of the bedroom doors were locked.

We recommend the provider seek further information on dementia friendly environments to support people's needs and enhance care.

When staff joined the organisation they received a flexible induction based upon their individual needs. Those new to care were encouraged to complete the Care Certificate. The Care Certificate was a recommendation from the 'Cavendish Review' to help improve the consistency of training of health care assistants and support workers in a social care setting. Staff also shadowed more experienced members of the team as part of their induction. The registered manager advised the induction and shadowing continued until new staff felt confident with people.

People were supported by staff who had received some training to meet their needs. Staff underwent training on essential subjects such as moving and handling, first aid and safeguarding. However, not all care and activity staff had completed dementia training or training in supporting people with behaviours which challenged staff. During the inspection staff told us the communal bathrooms were locked due to some people's behaviours in the bathrooms. Most people at the home were living with dementia. Further training in dementia care would support staff to develop skills to meet people's individual needs which may challenge staff. During the inspection we found staff required training in diabetes, continence management, managing people's nutritional needs and skills to support people with seizures.

We recommend additional training and updates in relation to the specialist needs of people living with challenging behaviour, diabetes, epilepsy, dementia and those with nutritional needs. This would support people to have better outcomes.

All staff confirmed the training provided was good and they were encouraged to complete nationally accredited qualifications. The action plan submitted following the inspection advised further dementia training would be sourced, all staff would have the opportunity to attend a virtual dementia experience and the activities staff attended training in this area shortly after the inspection.

The registered manager told us staff were supported by ongoing informal and formal face-to-face supervision, spot checks, competency checks and an annual appraisal. Staff were invited to come into the office regularly and confirmed an "open door" policy.

People's nutritional needs were met with frequent meals, snacks and drinks offered and available throughout the day. There were three areas where people could eat in addition to the lounge and one person we met ate in their room. There was little involvement evident from people in the planning of the menu and little choice offered. The menu was in the kitchen and not visible to people on notice boards, seating areas or the dining room. Nor was it available in a different format which people with eyesight difficulties might need. We saw no evidence of people being offered a choice of meal. The chef commented that people "in this section residents keep on changing their mind as they have dementia" when we observed everyone had the same meal at lunch (which was different to the meal on the menu). We asked four people whether they were given choices about their food. Two people said, "No" and the other two said "they offer, and we take it" and "we are usually told about the menu we are going to have during the day."

We observed that the lunchtime meal was not hot in the area staff called the Annex because it was taken on unheated trolleys from the other end of the house. One person told us that when they had previously commented on this to staff they had been told it could be microwaved for them. We spoke to the registered manager about the length of time people went from the evening snack meal to breakfast. They advised biscuits were available for people late evening. People shared their views on the food, "Very good, sometimes it is not enough though"; "Every other day soup, sandwiches and a handful of crisps"; "Ok"; "Oh, very good"; "Would be good to have more variety of diabetic deserts rather than just yoghurts and bananas" and "Average". Relatives told us, "A chart of drinking was put in place, they liquidised the food she likes when needed, yoghurt and mousse"; "Breakfast is served in his room" and "Too much, she has never been off her food." Drinks were offered throughout the day.

We observed staff asking people their choices of drinks throughout the inspection. Staff told us they recorded how much everyone ate and drank. We noted that although people's intake was recorded, there was no information on the total amount of fluid intake being aimed for each day. This meant there was not an overview of whether people had drunk enough to keep them healthy and to guide staff whether they needed to take further action.

People's care plans provided some details to help staff know what people's nutritional likes and dislikes were and highlighted any people who required support with their health needs or weight. However, one person's nutritional needs had significantly improved since their care plan had been written and did not reflect their current needs.

People were protected by staff that made prompt referrals to relevant healthcare services when changes to health or wellbeing had been identified. Staff knew people well and monitored people's health on a daily basis. Physiotherapists, dieticians, people's doctors, chiropodists and other health professionals were regularly involved as required. The visiting district nurse shared they felt communication was good with staff at the service and they were appropriately contacted for advice and support. Relatives also felt confident health and social care professionals were involved when required, "100%. Mum had a fit (seizure), I pressed the button and they appeared. Definitely they keep us informed"; "I believe so, yes. Response depends on availability of staff on duty. Yes they keep me informed; all are conveyed to me by the manager"; "Yes the doctor always comes here. As soon as they have any concern they call a doctor". We observed staff responded promptly on the second day of the inspection to call for the paramedics when one person's condition rapidly changed.

Changes in people's health were communicated to staff via regular handovers so staff were aware of people's needs. If staff noted a change we observed them seeking the advice and support of the registered manager. People and relatives confirmed they and professionals were informed of any changes promptly. Family told us, "Yeah, Doctor is called out to address people's needs and specialist nurses when needed. They tailor the needs according to patient as a person not a number". People confirmed changes in health were noted and quickly responded to, and during the course of the inspection we observed this. The registered manager advised people were encouraged to live healthier lives through staff education on food choices, encouragement to remain active through exercise and activity to provide meaningful stimulation. However, we found these discussions and plans were not always evident in to care records or meeting minutes.

We asked the registered manager how technology was being used to improve people's independence and provide effective care. We were told there were plans to have Skype (a free calling system) put on the lounge television so people could connect with family who lived away from the area. We spoke to the registered manager about how this area was a communal area and some people might wish to have more privacy.

Requires Improvement

Is the service caring?

Our findings

The previous inspection in January 2016 found the service to be caring. This inspection had noted people had not been involved in decisions made about their bedrooms being locked and not having a key to their rooms. The report also noted people had not been asked if they had a gender preference regarding staff supporting them with personal care needs.

At this inspection we found further improvement was still required to ensure people were treated as individuals, to be actively involved in decisions about their care and treatment as far as possible and for people's privacy, dignity and independence to be promoted.

On the first day of the inspection when we arrived, a member of staff opened the door. There was no greeting or welcoming from them and we were pointed to the manager's office, again with no introduction.

We observed staff spoke kindly to people and knew people well. Relatives and professionals also confirmed people were treated respectfully, "They usually are caring, they are good"; "They are caring, yes"; "They are very considerate". However, we found the lack of staff understanding about dementia meant care practices were not always person centred. When we questioned staff about people's involvement with residents' meetings, decisions about their care and treatment or fed back to staff what people had told us, there was an assumption their views or feelings were because of their cognitive difficulties. This may mean important things people shared with staff or others were missed or ignored. For example, one person throughout the inspection told us they were in pain. When we spoke with staff we were told they said that frequently. Another person told us, "I've never been so unhappy in my whole life, feel like I'm in prison"; "I feel low and think about going into the sea but am not brave enough". We fed back this person's low mood and were told their views changed regularly. Two people felt they were restricted at the service and powerless but care lacked discussions about opportunities which might be available to them given their circumstances. Staff did not go and check either person during the inspection.

Staff did not always treat people with dignity and respect at all times. When we arrived in the morning of the first day of the inspection we saw one person was in wet trousers. At the end of the day, they remained in wet trousers. This person was living with dementia and appeared unaware he was soiled. He relied on staff caring for him to observe and support his continence and cleanliness needs. This meant he was left for a considerable length of time in an undignified manner. Staff had not noticed and we were told the person could be resistant to personal care. On the second day of the inspection we saw they were in different, soiled clothes.

This is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People, who were able, told were mostly positive about the care they received when asked. Relatives were also positive about the staff and the care provided, ""Amazing, kind and compassion"; "They treat people with respect. I have never witnessed any unkindness. For improvement we need to support him with his needs"; "Very good, very caring, yes I can't think of any improvements because they are always asking about

[X] concerns." Relatives were also positive about the atmosphere within the service, "It's a very good one. I do love it. It feels homely and friendly"; "Very friendly, staff do the very best they can. My husband is quiet"; "It is good everybody is jolly together. Jolly atmosphere where staff encourage to laugh and we keep staff busy." Survey feedback from relatives included, "Very happy all round"; "Always friendly"; "Find the home helpful, caring and understanding."

Relatives shared their family members were treated with respect, "100% totally, when two patients are upset at each other, they always give you support"; "Yes, they always call me [X] and they positively interact with her (relative)" and "Yes I do feel people are treated with respect, they are discreet about residents that are incontinent. They shut the door when dressing and doing personal care."

Staff spoke of people in a caring, thoughtful way. Staff told us how much they enjoyed their jobs and the people they cared for. Good relationships with people had been built up over time. Staff feedback from a survey in June 2017 included, "I enjoy seeing the residents happy in the home."

Staff told us they supported and cared for people as they would their own family members. Staff we spoke with had a good knowledge of people and how they liked to receive their care. Staff told us they knew people's particular individual mannerisms and facial expressions if they were unable to verbally communicate. Staff gave us examples of how they communicated with people who were unable to verbally communicate and explained how they used hand gestures, facial expressions, pictures and written word to support understanding.

People's religious needs were met with a monthly church service and the registered manager informed us that last rites were read if people were Catholic and in their final days. If people were from a different culture or religion, the registered manager advised people's faith needs were met.

People's care plans detailed family and friends who were important to them. It was not always clear in the care records if people had others such as family members with authority to make decisions on their behalf. People, where possible and their relatives told us they were encouraged to express their views and be involved in all aspects of care but the people who were able told us they had not seen their care plan.

Most people at the service were living with dementia and had difficulty with understanding care plans. We discussed with the registered manager presenting care plans in an accessible format to meet people's needs if required. We were advised care plans and information could be provided in larger fonts and the registered manager was looking at how the accessible information standards could be further incorporated in to people's care following the inspection (The accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.) We discussed highlighting important information in care records so these needs were flagged and shared, if required.

We asked the registered manager whether relatives were invited to be a part of the resident meetings and were advised they did not wish to be. We saw that the last residents meeting had been in January 2017. We were told people didn't engage well with these meetings and the registered manager obtained feedback on a one to one basis instead. We saw that care was regularly reviewed by the registered manager but there was an absence of people's / relatives being involved in these care reviews.

Staff understood the need for confidentiality, the safe storage of people's records, and knew not to share information without people's consent or unnecessarily.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in January 2016 the service was rated as good. At this inspection we found improvement was still required to care records to ensure they reflected people's needs.

The registered manager advised referrals came through word of mouth and through the local authority system. The service undertook their own assessment of people's strengths and needs. Individualised care plans were then developed based upon the assessment people's needs. If people had protected characteristics under the Equality Act (for example age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation) the registered manager assured us the provider's policies ensured people were treated equally and fairly. The accessible information standard which requires providers to highlight and flag possible protected characteristics and communication needs was not well recorded in the care plans we reviewed. The registered manager told us they had been given information about this standard by email but due to sickness had not yet read and implemented this.

People had support plans in place but we found some care plans were out of date and did not reflect people's current needs or if their needs had changed. For example one person's mobility needs had changed since admission but their care plan did not reflect this. Their care plan stated they walked with a stick and needed the support of one staff member but now they used a wheelchair. Another person was at risk of choking and seizures but their care plan did not give guidance to staff on how to manage these areas. A further person had improved since their admission so their care plan was no longer relevant. The registered manager was aware some care plans were out of date and required updating.

Not maintaining accurate, complete and contemporaneous records in respect of each person is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's social interests and preferences were recorded in some care records and known by staff for example those who liked listening to music. One person who was nursed in bed liked a sensory ball on, which would light up the room and their care records noted they liked a particular singer. All family we spoke with told us care was personalised and met their relative's needs. Relative's comments included, "Yes I do (think care is personalised), [X] is not one of the numbers".

The Bill House was proud of the end of life care people received and health professionals felt end of life care for people at the service was good. No one we reviewed had end of life care plans in place. The deputy manager told us these were in progress. We also noted that only the registered manager had completed training in end of life care which meant other staff may not have the skills they needed to care for people at this stage in their life.

Those people we met who were at the end of their life and cared for in bed looked comfortable, were repositioned frequently, and were supported by staff to remain hydrated. The registered manager gave examples of how the service had met people's spiritual needs at this time. Staff had good working

relationships with doctors and the nurses to ensure people who might require pain relief had this promptly. Staff supported people who did not have family, and family members of other people were made welcome at the home and provided with comfort for as long as required.

People told us staff addressed them in the way they preferred and we noted bedrooms were personalised with people's belongings and the things which mattered to them.

The Bill House had three staff designated to provide activities although during the inspection the allocated staff member was required to provide care due to sickness. The registered manager told us they engaged people with board games, painting and conversation. Another staff member told us in the warmer months people enjoyed the local beach and they took people out for a drive. We were told people particularly enjoyed quizzes and a chat. Due to people's cognitive needs we were told people engaged better on a one to one basis. Occasional singing groups came to the home including a musician who played the guitar. During the inspection we saw people benefitting from individual staff contact, some having their nails painted and other people talking to their friends and reading magazines. However, there was little evidence of activities being personalised and reflecting people's past hobbies and interests.

There was a system in place for receiving and investigating complaints. Information about how to raise a complaint was visible in the entrance hall and the complaints policy was available in the office. We discussed the complaints received in the past 12 months with the registered manager. There were no written complaints but minor issues had been appropriately investigated and responded to. People, who were able, told us they had no concerns or complaints and if they did were confident the registered manager office would resolve these. People's feedback included, "I haven't had to complain" and "I never had to make any complaint after 2 years". If people using the service or their families required the complaints policy in an accessible format, we were advised by the registered manager this would be arranged. The Accessible Information Standard (AIS) is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Following the inspection an example of a pictorial complaints policy for people was shared with us by the registered manager. We were told this was visible to people using the service.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in January 2016, the service was rated as good. At this inspection we found improvement was required to the systems and processes in place to ensure standards of care reflected best practice and met the regulations.

The registered manager was well liked by people, professionals and staff. We were told they were approachable and visible. The registered manager told us, "Residents come first." They had good systems in place to ensure the service was safely staffed and staff were supported in the workplace.

The regional manager visited The Bill House most months on behalf of the provider to conduct audits and observations of care and talk to some people and / or relatives using the service. Quality assurance processes based upon the key lines of enquiry were in place and undertaken by the provider and regional manager but these had failed to identify the issues found at this inspection in relation to, maintaining people's dignity and autonomy, and care records not reflecting people's needs. Systems were not in place to identify risks and involvement with people, their family and friends was not always evident. Although staff received training in areas the provider deemed essential, staff had not received training in other areas to meet people's needs for example diabetes training, end of life training and epilepsy training. Observations had been conducted in the lounge and dining areas but had failed to notice the problems with the laundry system, that chairs were soiled and unclean, and the lack of choice of meals offered and the lack of a visible menu. Food and fluid charts had been recorded as checked but failed to recognise care plans did not detail what action to take from these and at what point. Checks conducted had stated compliance with the mental capacity act but we found the code of practice was not followed. Care based upon individual's needs and rights was lacking but had not been identified through the governance systems. Although a survey had been sent to people in June 2017, in January 2018 feedback had not been collated. We found some of the areas of concern at this inspection were also noted at the previous inspection and had not been acted upon. This showed learning had not taken place.

Most areas in the provider's quality assurance audits we reviewed for 2017 showed 100% compliance with the regulations. This did not reflect our inspection findings. Following the inspection, the regional manager wrote to us advising they recognised improvements could be made to the audit tool used. A new, updated audit covering the Commissions key lines of enquiry was sent to us.

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

Resident meetings were infrequent but we saw people and relatives had been asked for their feedback in June 2017. The registered manager had not collated the responses at the time of the inspection but responses we reviewed were positive. Relatives told us they regularly saw the registered manager and their views were listened to.

The registered manager worked in partnership with other agencies when required, for example primary

healthcare service, the local hospital, the local district nurses, pharmacy and social workers. The registered manager told us a new local forum for registered managers was being set up where best practice would be discussed and they were planning to attend. They confirmed attendance at this meeting following the inspection. There was minimal evidence of good links or access to community resources.

The provider, registered manager and regional manager were approachable and knew people and staff well. They told us they frequently walked around the building when at The Bill House and spoke with people, relatives and staff to check people were content. The registered manager told us the providers and regional manager were supportive and proactive if any training, equipment or maintenance was required to enhance people's care. However, we found there was a lack of knowledge and understanding about current regulations and best practice which meant the areas we identified had not been seen as inadequate.

Staff meetings were held and staff told us they felt involved, valued and listened to. Staff told us they were happy in their work, understood what was expected of them and were motivated to provide and maintain a high standard of care.

The registered manager and provider had a range of organisational policies and procedures which were available to staff at all times. We were advised these were in the process of being updated. The provider's whistleblowing policy supported staff to question practice. It defined how staff that raised concerns would be protected.

The registered manager and provider understood some of their responsibilities and the requirements related to the duty of candour. They promoted the ethos of honesty and learned from some mistakes but had not taken action on all the points raised in the last inspection report. However, inspection feedback was listened to and acted upon quickly to start to address the areas which we noted required improvement. Conversations were held with the regional manager and provider post inspection to share our concerns and areas which required prompt action. An action plan was submitted following these discussions by the regional manager and action to address areas discussed in this report was underway.

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 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 (1) (2) (a) (b) (c) People were not treated with dignity at all times. People did not have access to their private rooms. People did not have the support in place to enable them to be as autonomous and independent as possible.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) (2) (3) Need for Consent Care and treatment of people must only be provided with the consent of the relevant person. Where some people did not have the ability to consent to their care and treatment, best interest decisions had not always involved the relevant people and been not been recorded. As a result, some aspects of care delivery were unlawful.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (c) (d) (g) (h) Care and Treatment must be provided in a safe way for service users. People's risks to their health and safety were not always assessed.

	Person's providing care and treatment did not always have the qualifications to do so safely. Aspects of the premise were not safe. There was not a system in place to assess the risk of, and prevent, detect and control the spread of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1)(2) (a) (b)(c) Good Governance Accurate, complete and contemporaneous records were not kept in respect of each service user. The systems and processes in place were not sufficient to ensure compliance and assess, monitor and improve the quality and safety of the services provided.