Health Care Homes Group Limited

Bilney Hall

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 14 November 2014 and was unannounced.

It is a residential care home providing care and support for up to 54 older people, some who may be living with cognitive impairments. It is split between three units, The Old Hall, Dibben Wing and Liddell Unit.

There was a registered manager working at the service. 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 and associated Regulations about how the service is run.

During this inspection we found that care staff were not always available to support people when required. We also found that senior staff administering medicines were delayed in the process due to the volume of people requiring medicines.

Summary of findings

In certain parts of the building we found areas of risk that could have caused harm to people living in the home, staff or visitors.

People told us they felt safe and that staff supported them safely. Staff were aware of safeguarding people from abuse and knew who to report concerns on to. We found that accidents and incidents were monitored and acted on appropriately and that risks were assessed and reduced or removed.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We made a recommendation in this report that asked the provider to support staff with their understanding of this act.

We found staff were supported with induction and training but training to support people living with dementia, beyond the one day induction training, had not been given to the majority of staff.

People enjoyed their meals and were given choices. Drinks were readily available to ensure people were hydrated.

The health professionals in the community worked together with the home to ensure a suitable health provision was in place for people living there.

We found the layout of the home was difficult for people who may have memory problems or living with dementia as there were no visual prompts or signs to direct people.

All the comments we received were positive when talking about the staff team. We were told they were caring, kind, respectful and courteous.

People's needs were responded to but not always in a timely manner. People living with dementia were not being supported in the most appropriate way.

The manager had systems in place to monitor and audit the quality of the service provided. However, they were not found to be fully efficient in some areas of the service provided.

There were a number of breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

We found people were not supported by enough skilled staff to fully meet their needs.

Some areas of the home were unsafe due to trip hazards and unlocked areas that should have been secure.

Risks had been assessed and accidents and incidents were monitored and acted on to protect people from harm.

Requires Improvement

Is the service effective?
The service was not always effective

Staff received induction and training that enabled them to do the job required. However, they did not understand the implications of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

The staff supported people with their health care needs following guidance from health professionals.

Meals were supplied with choices and drinks were readily available to aid the prevention of dehydration.

Requires Improvement

Is the service caring?
The service was caring.

Throughout the inspection people spoke positively about the home, staff and support given. Relatives spoke highly of staff.

Although caring, the staff were found occasionally working in an institutionalised way.

Good

Is the service responsive?
The service was not always responsive.

Some people were left for long periods of time without support being given.

Care plan information was not used to the best advantage when supporting people living with dementia.

People were given the opportunity to complain and those complaints were acted upon appropriately.

Requires Improvement

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

Requires Improvement

Summary of findings

Systems required to monitor the quality of the service provided were not always effective and did not identify the areas that required improvement.

People, relatives, staff and health professionals spoke highly of the manager.

Bilney Hall

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 November 2014 and was unannounced.

The inspection team consisted of two inspectors and one specialist advisor who has an expertise in dementia care.

We looked at information that was gathered before the inspection such as the Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed any statutory notifications that the provider had sent us. A notification is information about important events which the service is required to send to us by law.

During the inspection we spoke with 11 people using the service and two of their relatives, six care staff, two senior staff and the manager. We contacted the health centre practice manager and the dispensing pharmacy to ask their opinion of the service provided. We conducted a Short Observation Framework for Inspections (SOFI) which is a process we use for observing care to help us understand the experiences of people who find it difficult to talk with us. We completed general observations and reviewed records. These included six care plans, daily records of a person's day, risk assessments, 10 medication administration records, staff training records, two personnel records and records relating to audit and quality monitoring processes.

Requires Improvement

Is the service safe?

Our findings

The manager informed us that forty nine people were living in the home at the time of this inspection. They had allocated eight care staff and two senior carers to support and care for this number of people throughout the day. The home was split into three units with a ground floor and upper floor in each unit. On the day of this inspection care staff members were designated to each of the units with the two senior staff carrying out medicines administration across the three units.

We found the provider could not ensure sufficient staff were working to meet people's individual needs. In one upstairs area of the Dibben unit, where seven people were living, a staff member told us they had to call for staff from another area to assist with three people who required two staff for assistance with personal care. They told us this was normal practice. Another staff member from Liddell unit also said it was accepted practice to support people who required two staff members for care tasks in other parts of the home. At this inspection we found some people were requiring assistance in the areas that were left unstaffed. For example, two people in Dibben were having a confrontation that placed them at risk of injury. In another unit, we observed one person needed assistance with using the toilet and not getting that support as their allocated staff member was working elsewhere. During the lunchtime meal in the Dibben Unit staff were supporting people with their meal by moving across from person to person to assist them with their meal. We were told by staff that four people in this unit required a staff member with them to support them with their meal and that not enough staff were on duty to enable a person to have the individual support required at mealtimes.

We observed senior staff who were responsible for the administration of medicines supporting a large number of people with their morning medication. For some people this was administered two to three hours later than stated on the medication administration record. For example, people on the Old Hall and Dibben unit were still receiving their medicines at 11.30am. One person in Dibben unit was heard shouting for pain killers. We looked at this person's MAR chart which stated the morphine sulphate tablets, strong pain killers, had been due at breakfast. This administration of these tablets did not take place until 11am. This person had not received their medicine since tea time the day before which should be administered at regular intervals to ensure the medicine was relieving the pain. The senior staff told us that two seniors were on duty to administer medicines so that people received them at the prescribed times. However, they also told us that the administration round did take a long time and that not everyone received their medicines at the time prescribed. Therefore there was not enough staff to safely meet the individual needs of people living in this home and the provider was found to be in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Time was spent looking at medicines management. We found that medicines were stored safely in a locked medicines trolley. The temperature of the medicines storage room was recorded to ensure the medicines were within the correct temperature range. Controlled medicines were stored safely and accurate recordings were seen in the register designated. Unused medicines were returned to the pharmacist with recordings made by senior carers demonstrating safe practice for returns. The senior staff members who were responsible for medicines administration told us they had been trained and assessed as competent to administer medicines.

We spoke with professionals in the community who supported the home with medicines. We were told the staff responded well to recommendations and advice, that people had their medicines available when required and stocks were managed safely so that people did not run low or out of their medicines.

People living in the home who required pain relieving medication had a pain assessment written that was reviewed on a monthly basis. However, it was not evident how people's pain was managed appropriately as we found some medicines were not administered at the prescribed times.

On our walk around the building we found the home to be clean and tidy. Hoists and lifts were serviced regularly to ensure they were safe to use. However, we found that some of the environment was not always protecting people from avoidable harm. A badly damaged carpet in the doorway of one bedroom was a potential trip hazard and a number of bedrooms had trailing wires from sensor mats or call bells. Some people, who were living with dementia, were seen wandering around Dibben unit where a cupboard door was unlocked that was used to store chemical substances that

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Is the service safe?

could potentially be dangerous. Although this concern was addressed at the time, we found the door again unlocked later in the day. In the upstairs lounge in this unit the sliding toilet door that was in the main lounge was off its runner and could not be closed if people used that toilet. One person was found trying to use this room with no staff available to assist them to another toilet.

People who were living in this home who were able to speak with us stated the care staff treated them well and they felt safe. One person told us, "I feel safe as the staff are kind to me." A second person said, "I feel safe and although we have had some security concerns in the home I feel safe and secure." The manager had informed us of these concerns prior to the inspection and had acted appropriately to ensure the premises were secure for people living in this home. One relative said, "The staff are very good and support my [relative] safely but they are really pushed and cannot support everyone."

The staff we spoke with told us they had received training on safeguarding people from abuse and would recognise the signs of abuse. They said they would report on any concerns to the manager. They also understood that any concerns were to be reported to the local authority.

We were told by the manager about the recruitment procedures the management team went through to ensure staff were suitable to work in the home. Staff we spoke with confirmed this procedure was followed. We found that staff were thoroughly checked for their suitability before being employed.

Risk assessments had been comprehensively completed in relation to individual needs. These were recorded in people's care plans and had been reviewed. Staff we spoke with were aware of the risks identified for each person. We noted them following the care plan information to meet the people's needs safely. For example, by using suitable equipment such as hoists or assisting people correctly when moving around the home.

Accidents, incidents and risks were monitored closely by the manager to look for trends or patterns. For example we noted that a person who had fallen had been referred to the community falls team. Another person who was having swallowing problems was referred to the speech and language therapy team for advice. People at risk of pressure area concerns were monitored. Records were kept in people's bedrooms, such as repositioning charts to relieve pressure in a timely manner. However, we found that some charts were not always completed and one record had significant gaps of 12 hours without a recording. The manager informed us that no one in the home had a pressure ulcer at the time of this inspection. However, they could not ensure that people requiring repositioning received that support in a safe and timely manner.

Requires Improvement

Is the service effective?

Our findings

On the day of this inspection we found people were left for long periods of time in chairs they could not move from without help. Three people were seen with a table placed in front of them which could act as a barrier if they wished to move. We also found key pad locking systems in use throughout the home in three internal areas. People who were unable to understand could not move to other areas of the building or out of the front door without staff assistance.

In March 2014 a supreme court judgement clarified the definition of a deprivation of liberty. It stated if a person lacked capacity to consent to arrangements for their care, was subject to continuous supervision and control and was not free to leave the service they were likely to be deprived of their liberty. Although the manager and senior care staff were aware of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), we found they lacked understanding and did not recognise when people were being deprived of their liberty. For example, where key coded doors prevented people moving from one area of the home to another. Mental capacity assessments had been completed to meet the requirements of the MCA. The senior staff told us no one was deprived of their liberty. The manager was unclear on how many DoLS referrals had been made to the local authority at the time of this inspection. They said they would ensure a full understanding of the deprivation of people's liberty would be fully cascaded to the staff team following this inspection. The provider needed to ensure there was not a risk that could deprive people of their liberty unlawfully.

The building is split into three areas and during this inspection it was difficult for people to orientate around the premises. We found that people had plenty of space in their bedrooms and that individual belongings had made the room homely and familiar for them. However, in the communal areas there was no signage to help people with a sensory or cognitive impairment to find their way around. There was no sensory stimulation or different coloured features such as brightly painted hand rails or information signs to aid people memories. The only prompts seen were two calendar style memory resources, 'tell me about the day' and a dated clock all of which were out of date and therefore confusing. The main lounge used for activities in the main part of the home was well furnished but poorly lit at times making it difficult for people with visual problems. The environment was not adapted to suit everyone especially those people living with dementia. The manager informed us that the provider was planning redecoration for one area of the home and that the people who were living there would be consulted with for their ideas.

One relative and people living in the home were complimentary about the staff team and their ability to do the work required. People said that the staff were skilled and able to offer the care and support they required. One comment was, "They know what they are doing and do it well."

Staff told us they had a good induction and that support was available to help them understand their role. One staff member, who told us they were new to care work, was offered additional days to shadow staff to assist with their learning. Some staff we spoke with told us they had received one day's training on dementia care as part of their induction. Staff who had worked in the home for a period of time said they were supported with training and kept up to date with the mandatory training expected by the provider of the home. However, they said they would benefit from more training in dementia care. The manager told us that 14 staff out of 68 staff employed in the home had completed a diploma in dementia care and that more support for staff in developing their dementia skills was planned.

The staff we spoke with told us the team of staff worked well together and that relevant information was passed between staff effectively to ensure people were supported appropriately. They told us they had received supervision support from management but that they were not completed regularly. The manager told us staff appraisals were completed annually and this was confirmed by staff.

People told us their meals were good. We heard from three people how they enjoyed their meals and that they could have something different if they did not like what was offered. One relative said, "The people enjoy having their lunch in the main dining room. They have a good chat and laugh together." When we asked people what they were having for their lunch many could not remember. The senior carer told us that meals were chosen the day before. There were no visual prompts available, menus were not displayed and when found, were out of sight on a stand in the corridor in very small print. People were not supported

Requires Improvement

Is the service effective?

with suitable methods to aid their choice of meals in a timely manner especially for those people with memory concerns. Therefore, they could not remember what they were having until the meal was served.

The people seated in the dining room told us they enjoyed their meal. Many people living in the home had their meal in their room. We heard staff approach people in their room courteously with their meal. We noted drinks were regularly available throughout the home and people were encouraged by staff to drink. We saw one person who required support due to swallowing difficulties had been assessed and that the recommendations made, such as a soft diet, were being followed by staff.

The manager informed us that all newly admitted people were registered with the local GP surgery and that on-going support was provided by relevant health care professionals. We read in care plans how people were supported by the district nurse and other relevant professionals. The people we spoke with told us they could see the GP whenever they asked and that they felt supported to meet their healthcare needs. We were given an example of the support provided by the community health professionals to help the staff team offer the correct care and support to a person who had complex health needs. In all care plan records we looked through we read detailed recorded information following visits from health professionals.

We recommend that staff are supported with their understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

Good

Is the service caring?

Our findings

Throughout the inspection we received positive comments about the care the staff provided and how it was given. Expressive words such as, 'kind, considerate, friendly, courteous and compassionate' were just some used. Relatives told us the staff were great. One family member said, "I cannot fault the staff. They are so kind and caring."

All staff seen where noted to offer respectful and caring support to people as they were assisted with their care needs. Dignity was observed when people were quietly helped to the bathroom and the door closed. On entering a bedroom, staff were seen knocking before going in and we heard pleasant conversations where the staff member explained why they were there and if the person was happy with what was being asked. Kitchen staff were seen supporting people with regular drinks throughout the day. They were doing this in a respectful and supportive manner with lots of smiles and friendly conversations taking place.

Although it was evident staff knew the people well and comprehensive histories and relevant care and support needs were logged in the care plans for staff to read it was not evident how this knowledge was used when supporting people living with dementia. For example, a person who was showing distress was not given appropriate support by using the information in their care plan to help alleviate their distress. Staff, although kind and respectful, did not use the information available to manage the situation in the most appropriate manner.

Relatives and those people who were able to voice their opinions and choices were involved in the decisions about the care provided. This was evident in the care plans we looked through. However, one relative told us they were involved in the initial care plan but had not been involved in any 'official' reviews since. They told us they could visit as and when they wished and felt welcomed when more informal conversations about their relatives care could be discussed. They said the staff were very friendly and that the manager listened and was very supportive.

Although we found people were treated kindly and staff were caring, support was sometimes carried out in a task like manner. For example, in one lounge we were told people were 'toileted' around 12pm to be ready for dinner and we saw everyone was assisted to the toilet around this time.

Requires Improvement

Is the service responsive?

Our findings

When we asked some people how they spent their day they told us they stayed in their rooms until it was lunchtime or an afternoon activity was taking place. Another person said they only saw staff when they received a drink, meal or some form of care support. They told us they had little to do, had no interests and slept in their chair most of the time. A further person, whose room was quite isolated, said they were left for long periods without seeing anyone. However all four people said they were happy and the staff were nice but they would like to see them more often.

One person receiving support in bed in the Old Hall had a blank wall at eye level with no pictures or objects to look at. However, staff told us relevant information about this person and details were written in the person's care plan that could have been used as a means in supporting this person with some personal interests. We found individual needs were not focussed or centred around the person. Staff were working effectively on tasks required but not supporting people with their interests or social enjoyment.

The information we read in some care plans gave detailed information tailored to the person the care plan belonged to and how best to support the person. We read comprehensive information that described the support and care required. One relative told us they had been very involved in the initial assessment and planning of care and as a regular visitor was up to date with ongoing changes that were required to support their family member appropriately. This relative told us their family member was able to say what they liked and could participate in making choices which they said were listened to and acted on. However, for some people, it was not clear how the detailed care plan information was used. Staff in one unit had decided to have a modern music radio programme on. People were not interacting and showed no interest in the radio. Three people had books placed in front of them but again no one was showing any interest. On looking in one book we noted it was full of music scores and, on asking, found this person could not read music. Another person had a chocolate bar on their table but just out of reach so could not have picked it up if they had wanted to. Although care plans were detailed, individual support to promote people's interests and well being was not offered to people who were living with dementia.

People from all units who chose to, were assisted to the main lounge in the Old Hall in the afternoon where entertainment was provided. People we spoke with told us they had regular activities in this lounge and that they liked taking part. People showed their enjoyment when it had finished with lots of chatting and smiles. We were told entertainment or activities were only in the afternoons during the week. One person said, "Very little happens at the weekend so I stay in my room." Those people who did not wish to join in the activity had limited support from staff who were busy assisting with those who wished to be in the activity.

People living in the home and the relatives we spoke with told us the manager and staff listened to their concerns and tried to resolve them. One person said, "I only have to talk to [staff member] and the problem is dealt with." The manager told us they would spend time talking to people, which was confirmed by people living in the home and a relative we spoke with. They also said they had a regular resident/relatives meeting to discuss any concerns, changes taking place in the home or ask for feedback that may help with the development of the service provided.

People were given the opportunity to complain if they were unhappy with the service and a complaints procedure was available. The manager showed us the three complaints they had received in the last year. We saw what action was taken and recorded and that the issues raised were resolved. The manager said they used concerns and complaints as a learning process and staff would be involved in resolving any concerns about the service.

Requires Improvement

Is the service well-led?

Our findings

During this inspection it was evident the home required improvements in a number of areas of the service. The manager had a system for checking the quality of the health and safety throughout the home but some areas were unsafe, showing effective systems were not in place. For example, action had not been taken on concerns found around the home such as trip hazards with damaged carpets and trailing wires, unlocked doors housing dangerous substances and a damaged toilet door. The care plans were reviewed regularly but the information was not always followed especially around people's social needs. Therefore, the delivery of the care and support was not fully monitored to ensure it was suitable. Medicines were regularly audited but delayed times of administration had not been identified as a risk and action had not been taken to improve the process. Although the home had a dependency tool to measure the needs of people living in the home and extra staffing hours were available when required the staffing levels did not meet the individual needs of those people living in the home to ensure they had their needs met in a timelyand appropriate way. Therefore the provider did not have effective systems in place to monitor the quality of the service provided. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Throughout this inspection people living in the home told us how supportive the management team were. They said the manager always had time to speak with them and that they could go to the office at any time and that they would be listened to. One relative had previously told us they had not been involved in annual reviews for their family member. The manager had already informed us, as part of the information received prior to this inspection, that annual reviews, involving family members were part of the improvement plan. We received numerous positive comments about the management with one person saying, "The manager is approachable and a lovely person."

Staff spoke highly of the support provided by the whole staff team. They told us they worked well as a team and would support each other. This was noted when help was needed in various areas in the home. They knew what they were accountable for and how to carry out their role. They told us the manager was very approachable and that they could rely on any of the staff team for support or advice. They told us about staff meetings they attended and that minutes were available for staff unable to attend. Staff knew what was expected of them and felt supported.

Those staff spoken with told us they would have no problem with whistleblowing if they had any concerns about poor practice in the home. Interactions and involvement between staff members were seen throughout the inspection to be positive and carried out in a friendly, professional manner.

Looking at information we held about this home we found that the manager informed us in a timely manner of situations, known as statutory notifications. These notifications told us about serious incidents or events that could have affected the service provided and what the management was doing about the situation.

Medical professionals we spoke with told us they had worked together to build a strong working partnership with the staff team, with good communication systems in place to meet the healthcare support required for people living in the home.

The manager told us that yearly questionnaires were sent to people living in the service and their relatives to ask their opinion on the quality of the service. This was confirmed by some people and a relative we spoke with who also told us about relatives meetings held to update and involve families in the life of the home.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **People living in this home were not protected against the risks associated with insufficient staff who could meet their needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Effective systems were not in place to assess and monitor the quality of the service.**