Healthcare Homes Group Limited

Bilney Hall

Inspection report

East Bilney
Dereham
Norfolk
NR20 4AL

Tel: 01362860246
Website: www.healthcarehomes.co.uk

Date of inspection visit:
28 June 2016
30 June 2016

Date of publication:
10 August 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

This inspection took place on 28 and 30 June 2016. The first day was unannounced.

Bilney Hall is a service that provides accommodation and residential care for up to 64 people, most of whom are living with dementia. The home is split into three 'wings' which are called Liddell, Dibben and Old Hall. During the inspection, there were 49 people living at the home.

During our last inspection in November 2014, we found that improvements were required in some areas. These included improving staffing levels within the home to meet people's needs and preferences, staff knowledge of the deprivation of liberty safeguards and the provision of meal choice to people. Improvements were also required in the monitoring of the care provided within the home and the environment for people living with dementia. These concerns resulted in two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond with two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that sufficient improvements had not been made in all of these areas and that other concerns were found during this inspection visit. These concerns resulted in six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

There was a registered manager working at the service but they were not present during the inspection. 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 home is run.

The provider had failed to make sure that the required improvements identified during the last inspection had been made. There was a lack of effective systems in place to assess, monitor and improve the quality and safety of the care people received.

There were not enough staff working in the home to meet people's individual needs and preferences and to keep them safe. Some risks to people's safety in respect of the premises had not been identified in a timely manner. Where risks had been identified, actions had not always been taken to reduce the risk of people experiencing harm.

The principles of the Mental Capacity Act were not always being followed when making decisions for people who lacked the capacity to consent to their care. Therefore, people's rights may not have been protected. Some areas of the environment had been improved to assist people living with dementia. However, these

improvements had not been extended to all relevant areas of the home.

People received their medicines when they needed them and they received enough to eat and drink. People were supported to maintain their health and were able to make choices about the care they wanted to receive.

The staff were observed to be kind when they engaged with people but a consistent caring approach was not always demonstrated. People and visitors found the staff approachable and felt comfortable to make a complaint if they were unhappy about any aspect of the care being provided.

We have made a recommendation regarding improving the environment for people living with dementia.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff to meet people's needs or keep them safe.

Some risks to people's safety and the premises were not being adequately managed.

The systems in place to reduce the risk of people experiencing abuse required improvement.

The required checks to make sure staff were suitable to work in care had not taken place.

People received their medicines when they needed them and their medicines were stored securely. However, improvements were required where people received their medicines covertly.

Lifting equipment had been regularly serviced to make sure it was safe to use.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had received relevant training but they did not receive adequate supervision to monitor their care practice.

The principles of the Mental Capacity Act 2008 had not always been followed when making decisions for people who could not consent to the decision themselves.

The environment for people living with dementia required improvement.

People were supported to maintain their healthcare.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The staff spoke to people in a polite manner but people were not always treated with respect.

People were involved in making decisions about their day to day care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's individual care needs and some of their preferences on how they wanted to be cared for had been assessed. However, the lack of staff meant that some people's needs and preferences were not always met.

People knew how to complain but their complaints were not always dealt with in a timely manner.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems in place to monitor the quality and safety of the care provided were ineffective at identifying and assessing concerns and mitigating risks to people's safety.

There was an open culture where people living in the home and the staff felt able to raise concerns without hesitation.

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

This inspection took place on 28 and 30 June 2016. The first day was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us. We also requested feedback from the local authority quality assurance team.

During the inspection, we spoke with 11 people living at Bilney Hall. Most people were only able to provide us with limited feedback about the care they received. We also spoke with three relatives, six care staff, the cook, a head of care, the health and safety advisor and the regional manager who both represented the provider. Along with general observation, we used the Short Observational Framework for Inspection (SOFI) to assist us with this. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The records we looked at included eight people's care records, eight people's medicine records and other records relating to people's care. We reviewed three staff recruitment files and staff training and supervision records. We also looked at records relating to how the provider monitored the quality of the service.

After the visit we requested further information from the provider in relation to staff training and how the quality of the service provided was monitored. This was received promptly.

Inadequate

Is the service safe?

Our findings

During our last inspection on 14 November 2015, we found that there were not always enough staff available to meet people's needs. This had resulted in a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We asked the provider to make improvements within this area. The provider wrote to us and told us they would be meeting this regulation by end of May 2015. At this inspection, we found that the required improvements had not been made. There was still not enough suitably qualified and experienced staff deployed to meet people's needs and to keep them safe.

We received mixed views from people in relation to the staffing levels in the home. Two of the four people we spoke with about this told us that there were enough staff available to support them when they needed assistance. One person said, "Yes, they [the staff] come when I need them, that is not a problem." Another person agreed with this.

However, two people said they did not think there were enough staff to support them. One person told us, "I don't think the staff have time. For example, today my ankles are swollen and someone told me to keep them up and they would come back and take a look later. Did they come back? No way, of course not because that is how things are here." Another person said, "Sometimes I have to wait a long time (for help with personal care). Sometimes I've called [the staff] and ended up trying to do (personal care) myself because nobody came in time." They added, "I feel this place is very understaffed, although what they do for me I couldn't do at home alone for myself. I don't complain about anything really because they [the staff] are trying their hardest."

The three relatives we spoke with told us they did not think there were always enough staff to keep their family member safe or meet their needs. One relative told us, "[Family member] was attacked and hit by another resident using a walking frame recently. The staff did respond quite quickly to the attack and [family member] wasn't hurt as such. The [person] who attacked [family member] had been wandering in and out of [family member's] room a lot. They [the staff] did put down an alarmed mat in the room to try and warn staff when [person] was on the move, but it didn't prevent this incident or some of the others either." Another relative said, "They look after [family member] quite well, but they do seem short staffed at times which I know can cause problems because they have to dash about."

The home was split into three wings. Each wing had a ground floor and first floor unit. Care staff worked in two teams, one to cover one wing and the other to cover the remaining two wings. Five of the care staff we spoke with told us they did not feel that there were enough staff to meet people's needs in a timely manner or to keep them safe. The three other staff we spoke with said they felt that they could meet people's basic care needs. However, they added that regularly this was provided to them in a rushed manner. One staff member described it as being, "…quite hectic here."

Two staff members told us that sometimes they felt staffing levels bordered on unsafe. They described difficulties given the number of people who needed two staff to assist them with their care. Two other staff

said that it was common for them to be called away from their unit to help to support people on another unit who needed two staff with personal care. They told us that, on occasions, this resulted in the unit having no staff, with one staff member telling us that sometimes they had found people had fallen on the floor in their absence.

Another staff member told us they were not always able to attend to people's needs promptly or flexibly. They explained that people's needs had increased and that therefore, more people needed assistance with personal care. A different staff member echoed this. They told us that people's care needs had increased with a number of them needing support from two staff. They said however, that they had not seen any increase in the staffing numbers in relation to this.

During our observations, we saw that there were times where there were either no care staff on a unit or they were not readily available as they were helping people with personal care. On one occasion, we found one person in the room of another who was in bed. They had entered this person's room in the past and had therefore been identified as a risk to the safety of the person who was in bed. The person had a sensor alarm mat placed at their door to alert staff if anyone entered their room. The person who had entered this room had activated the alarm. However, staff were busy providing someone else with personal care so had not reacted to the alarm to ensure the person's safety.

On another occasion, no staff were available to supervise people within the communal lounge of one unit for 25 minutes, as they were both providing one person with personal care. Some of the people within the lounge were at high risk of falling and would forget to use their walking frame without prompting from the staff. Others were vulnerable in that they could not move out of their chairs without assistance. We heard one person say, "There is nobody here…" as they got up from their chair to look for staff because they were hungry.

On the morning of the second day of the inspection, we walked onto the ground floor of one unit to find no staff member present. There were four people present within the unit. After five minutes a kitchen assistant entered the unit to provide people with a drink. They were on the unit for five minutes. The care staff member then returned onto the unit. They told us they had been upstairs covering for a colleague who was on their break. They said that the upstairs unit in turn, did not have any cover as they were now covering downstairs. They told us that some people within the ground floor unit were at risk of falling.

Records we looked at documented that one person had had a fall during the night in May 2016 which has resulted in them being injured. We spoke to a senior staff member about this. They told us that a sensor alarm mat had been in place to alert staff if this person left their room because the person's room was near some stairs. However, the two staff covering that unit were assisting another person with personal care. They had been unable to respond quickly when the alarm mat had been activated, to intervene and prevent the person from falling.

We checked the staff duty rota for the two weeks prior to the inspection. The number of staff required by the provider to work in the home at various times during the day had not been met on nine of the fourteen days. On two occasions, the number of staff required to work during the night had not been met.

We spoke to the regional manager about our concerns regarding staffing levels within the home. They told us that the number of staff required was based on people's individual needs but added that the system used did not take other factors into account such as staff taking breaks or the layout of the building. They said that they had recognised that people's care needs had increased and that therefore, the provider was introducing a different system to calculate the required staffing levels. However, this still did not take into

account these extra factors that could have an impact on the staff's ability to provide people with the care they needed in a timely manner. They also added that they had recognised that there were not always enough contingency staff to cover absence. They told us that they were therefore exploring the use of agency staff.

This evidence demonstrated that there was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Risks to people's safety in relation to the premises had not all been adequately managed. Radiators in the communal areas of the home were covered to protect people from exposure to hot surfaces. However, when we checked seven people's rooms at random, we found that not all radiators within these rooms were covered. All of these people had poor mobility and were at risk of falls which posed a risk to their safety should they fall against a hot surface.

The provider's health and safety advisor told us they had conducted a risk assessment in June 2016 in relation to hot surfaces within the home that included the radiators. We saw a copy of this risk assessment. They had identified that there were 18 unprotected radiators within people's rooms that posed a risk to their safety. A further recent audit had identified some additional radiators that posed a risk.

We noted that two of the radiators we checked within people's rooms were not identified within this audit. The health and safety advisor viewed these radiators and told us these should have been included within the risk assessment. The original assessment of risk had therefore not been accurate or robust. They subsequently conducted a further audit within the home at the request of the inspector. A plan is in place to take action in relation to this risk in mid July 2016.

Some people who lived in the older part of the home had portable heaters within their rooms. This was because the fixed radiators did not provide them with adequate warmth. We looked at one person's care record in relation to this. We found that the registered manager had assessed the risks posed to this person from using a portable oil-filled radiator. However, the identified risks related to the equipment itself and its safe usage or storage when it was not in use. We noted from this person's care record that they were at high risk of falls and had a history of falling. The risk assessment for the oil-filled radiator had not taken this into account. This was important to consider so staff knew where to position the equipment to minimise the risk of the person falling into the heater, risking injury or knocking it over. Therefore, the risk of using the portable heater had not been robustly assessed.

The fire service had conducted an inspection of the home following a recent incident. They found that the home was in breach of some areas of the Regulatory Reform (Fire Safety) Order 2005 which placed people at risk in the event of a fire. The fire risk assessment was not suitable as it had not considered who may be especially at risk in the event of a fire. Potential ignition sources within the premises had also not all been identified. The fire service found that a large area of the basement was not fitted with a smoke alarm. They had therefore declared the existing fire detection system inadequate. The basement had had a large area of ceiling removed that had exposed the wooden floor of the ceiling above. The structural fire precautions were therefore declared as having been inadequately maintained. Many of the internal doors within the home were found to not be sealed fully when they were closed. The provider had received a report from the fire service in relation to these issues. The health and safety advisor told us that plans were in place to address these concerns.

During our inspection, we noted that someone had removed the 'barrel' of a lock to one bedroom door. This left the door with a hole straight through it where the lock had been. This room was occupied and presented

a risk to the person within it should a fire break out because the integrity of the fire door was impaired. The person living in the room would not be properly protected until they could be evacuated or, if a fire broke out in that area, there was a risk it may not be properly contained. We brought this to the attention of a senior staff member.

Risks in relation to people falling, not eating and drinking and developing a pressure ulcer were looked at. These had all been assessed and clear actions had been documented within people's care records regarding what action staff needed to take to reduce these risks. However, risks in relation to people falling and not eating and drinking were not being managed effectively. This was because the actions required to mitigate the risk to people were not always being taken.

It was documented within one person's care record that, in the past, they had sustained a fall from their chair. To mitigate this risk, it had been recorded within the person's falls risk assessment that staff had to make sure that their walking frame was beside them at all times. A pressure mat was also required to be beside the person's chair. However, we observed that when the person was in their chair, their walking frame was out of their reach and the pressure mat was stored under the bed.

Two other people's care records showed that they were at high risk of falls. Again, to mitigate this risk these people should have had their walking frame near them as they would forget to use this. However, over the course of the inspection we saw one of these people walking around a unit without their frame on two occasions. Also, their frame was not always near them when they were sitting in the lounge area. The visiting hairdresser intervened quickly with the other person when they were walking without their frame. However, the frame they brought to the person had been near the lounge and so had not been available to them in their room when they needed it.

We observed in one person's room that between the bed and the cabinet where the radiator ran, trailing wires were on the floor. This person had been assessed as being at high risk of falls and was mobile within their room. This therefore presented a further risk of falls.

Two staff were observed to use poor moving and handling practice when they supported one person to stand. They asked the person to place their hands on their frame when rising from sitting into a standing position. This made the walking frame move forward as the person got up. Although no harm came to the person, this technique placed them at risk of falling.

The risks of people not eating enough had been assessed using the Malnutrition Universal Screening Tool (MUST). However, actions that had been identified to reduce the risk of people becoming malnourished had not always been taken. Some people had been identified as needing to be weighed either weekly or fortnightly to make sure they were not losing weight but this had not always occurred. We also found that the MUST had not always been completed correctly which meant that the overall risk had on occasions, been underestimated.

A speech and language therapist (SALT) saw one person as there were concerns about their ability to eat and drink safely. The SALT had advised that, to ensure the person was safe when eating and drinking, they needed to sit upright. However, we observed one member of staff give this person a drink whilst they were lying back in their chair. This resulted in them coughing and placed them at risk of aspiration (fluid going into the lungs).

Risks to people from burns or scalds from hot food and drink had been assessed. These identified that people using 'beakers' might be at risk if lids were not fitted properly and that the temperature of food

leaving the kitchen needed to be considered. However, the staff had not been provided with adequate equipment to enable them to test the temperature of the food before they served it to people. Therefore, they were not always able to effectively mitigate this risk. We noted that one person was presented with a dessert, which they started to eat without staff supervision. We heard them say, "I think I've burnt my mouth." When we looked further, the dessert contained jam, which holds heat and was steaming. On another occasion, we saw that two hot meals had been left within the kitchen area uncovered. When we asked staff why this was, they told us that the food had been steaming and so they wanted it to cool down before giving to the people to reduce the risk of them burning their mouths. The staff had to 'guess' the temperature of the food before they served it. The health and safety advisor told us that they were in the process of obtaining temperature probes for the food to assist staff with this.

The evidence demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We checked three staff recruitment records and found that the required checks had not taken place before the staff member started working in the home. We found that each staff member had been checked to make sure they had not been barred to work within care, and their identification had been ascertained. However, two staff had previously worked within care but a reference from their previous employer had not been obtained. We also found that in one case, the staff member's previous employment history had not been explored. When asked, the regional manager was unable to explain why these checks had not occurred. For another staff member who had not previously been employed, only two character references had been obtained when the regional manager said there should have been three. Therefore, the provider had not fully explored whether these staff members were suitable to work within the home prior to their employment.

This evidence demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

All of the people we spoke with told us they felt safe living in Bilney Hall. One person said, "I feel safe here." Another said, "I feel safe here because the staff seem to be family people and I can talk freely with them." The visiting relatives we spoke with agreed with this. One relative told us, "[Family member] is safe here." They went on to tell us that they were kept informed of any incidents that occurred.

The staff we spoke with understood the different types of abuse that could occur. They told us they would report any concerns they had to the registered manager or senior staff. We saw that there was information within the different units of the home advising staff who they could contact if they had any concerns. However, it was documented within two people's care records that they had experienced some unexplained bruising. When we asked a senior member of staff about this, they reviewed these people's records and told us there was no evidence to show that either of these incidents had been investigated. Therefore, the registered manager could not ensure that any necessary action could be taken or whether these incidents were safeguarding concerns. Improvements were required to the current systems to make sure that people were protected from the risk of abuse.

We received mixed feedback from people regarding whether they received their medicines when they needed them. One person told us, "Oh yes, I always get my tablets when I need them. I have no problems there." However, another person told us, "I take my medicine at various times but they are not always punctual." Another person said, "I take three tablets in the morning and two at night. They aren't always exactly on time, but more or less I suppose."

We found that people's medicines were stored securely so they could not be tampered with or taken inappropriately by the people who lived in the home. The records we checked indicated that people received their medicines as intended by the person who prescribed them.

We observed staff using good practice when giving people their medicines. They asked people if they were ready for their medicine and stayed with them until they had taken them. The medicines trolley was locked and the key removed when it was unattended for the safety of the people living in the home.

There was clear guidance in place for staff to follow if they needed to give people a medicine that had been prescribed to them for occasional use. This was in place to make sure that staff gave people their medicines safely. We also saw that staff noted the time they gave people their pain medicine so they could ensure an adequate gap occurred between the doses.

Some people who lived in the home were receiving their medicines covertly. This meant that the medicine was hidden within food or drink and that the person did not know they were taking it. We checked how these medicines were being given to two people. For one person, we saw that staff had consulted with the person's doctor about how to give them their medicines safely. However, for the other person there was no guidance in place for staff. When we spoke with a senior staff member about this, they were unclear whether the way they were giving the medicine was safe. Improvements are therefore required to make sure that the relevant information is gathered and guidance in place for staff before giving people their medicines covertly.

Risk in relation to people experiencing a pressure ulcer had been managed well. We saw that the required equipment was in place and that people were being re-positioned regularly to reduce the risk of them experiencing a pressure ulcer.

Lifting equipment that was used to support people to move had been regularly serviced in line with current guidance to make sure it was safe to use.

Requires Improvement

Is the service effective?

Our findings

During our last inspection on 14 November 2015, we found that improvements were required to staff's knowledge in respect of how to apply the Mental Capacity Act 2005 (MCA) deprivation of liberty safeguards (DoLS). At this inspection we found that improvements had been made. People had been individually assessed to ascertain whether they were being deprived of their liberty in their best interests. Applications had been made to the supervisory body as is appropriate and the provider was awaiting the outcomes.

However, the principles of the MCA had not always been followed when making decisions on behalf of people. The 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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Where asked, people told us that the staff asked for their consent before performing a task. One person told us, "I find staff polite and they will ask permission before they do anything such as if I'm ready for my medication, or want to eat." Another person told us, "Yes, the staff always ask me first what I want to do."

Most of the staff we spoke with had an understanding of the MCA and how it affected their daily practice. They understood the importance of seeking consent from people before they offered support. For example, they told us that, if someone refused assistance with personal care, they would return later and ask again. They also said they supported people to make decisions for themselves such as showing them a choice of clothes they could wear if they were not able to verbally communicate what they wanted.

We observed that staff asked people for their consent before delivering care. For example, staff asked people if they wanted assistance to cut up their food. We also saw that someone who needed assistance to transfer to an armchair, using the hoist, was asked if they were ready for help. Another person was offered an apron ready for them to eat their meal and people were shown the two alternative meals that were on offer so they could make a choice.

Although staff understood the importance of seeking consent, the principles of the MCA were not being applied consistently. We did not always see evidence that the provider had assessed whether people could consent to certain decisions about their care before making a decision on their behalf. Also, there was no information to show how the provider had tried to support the person to make a decision about their care. For example, one person had a sensor mat by their bed to monitor their movements. A capacity assessment had been conducted which deemed the person not to have capacity to consent to this decision. It was clear from the records that this was in place in their best interests. However, another person also had a sensor mat in their room, but they had not had their capacity assessed in relation to this.

Where medicines were being given to people covertly, one person's capacity to consent to this had not been assessed although a best interest decision had been made involving the relevant people. For the other person whose records we looked at, we found their capacity assessment stated they had capacity to make decisions about their medicines. But when we spoke to a senior member of staff about this, they told us that this was incorrect and that the person had fluctuating capacity but that this had not been formally assessed.

We also found that the specific decision people had been asked to consent to had not always been well documented within the care records we viewed. For example, we found that there were documents within people's care records stating they were MCA assessments about specific decisions the person would need to consent to. However, it was not clear what the specific decision to be made was. For example, one person's ability to consent was described only in terms of "safeguarding" and "prevention of pressure ulcers." There was no consideration of what was meant by either of these. Therefore, there was a risk that decisions could be made on behalf of people that were not following the principles of the MCA.

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

All of the staff we spoke with told us they felt they had received enough training to provide people with effective care. This included training in moving people, first aid and health and safety. They told us that most of their training was practical training and that e-learning had also been recently introduced. We checked the staff training matrix that held information in relation to the completion of staff training. We saw that training for some staff was overdue. However, we were advised by the regional manager that this training had been booked to take place in August and September 2016.

Most staff told us they could not recall having recent formal supervision meetings with their relevant senior member of staff. Supervision is needed so staff can discuss their performance, development and training needs. We therefore checked to see what formal supervision staff had received. We found that staff had not always received appropriate supervision to ensure they provided people with effective care.

We were informed by the regional manager that the provider's expectation was that all staff were to receive four formal supervision meetings each year including an observation of their practice. However, of the four staff files we checked we found that none of them had received the required amount of supervision. We also found that one staff member was required to have more frequent supervision due to an issue with their care practice. However, this had not taken place. We observed this staff member using poor practice during the inspection when assisting one person to stand.

Some staff working in the home were part of the provider's apprentice scheme. We were advised by a senior staff member that the apprentices could only provide care that was supervised. However, we saw one apprentice giving one person a drink and tending to people within the lounge area of the home unsupervised.

New staff who started working in the home completed induction training. One staff member told us how they had shadowed a more experienced member of staff before they started to work on their own. However, we did see not any documentary evidence to demonstrate that new staff had been deemed competent to work independently with people before they were allowed to do so. The regional manager agreed that this should have taken place and could not provide an explanation as to why it had not.

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

During our last inspection on 14 November 2014, we found that improvements were required so people

could make a decision about which meal they wanted to eat. We saw that improvements had been made in this area. The people we spoke with told us they had a choice of meal and drink each day. The menu was on display so people could see what was on offer. If they were unable to read the menu, the staff were observed to show people the meals on offer so the person could make an informed choice.

We received mixed feedback from people about the quality of the food. One person told us, "The food is absolutely excellent, I cannot fault it." Another person said, "I find the food here okay. There is always enough to eat, but the food is old fashioned, for example Chili Con Carne served with boiled vegetables." Another person said, "I will go as far to say the food here is acceptable." They added however, "I would like some other sorts of food, but I doubt I'd get it so I'm not asking." A further person said, "The food is quite well cooked and when we last had a power cut the kitchen made sure we all got some cold food. They coped very well." They added, "The fish is wonderful."

We saw that if people did not want something that was on the menu that they were offered an alternative. Some people who finished their meal were asked if they wanted another helping. There were snacks and drinks available for people to help themselves to during the day.

The cook told us that communication to them about people's dietary requirements was good. They were able to tell us about the different diets that people required to meet their needs. Action had been taken to improve people's calorific intake and referrals had been made to the appropriate healthcare professionals when needed for specialist advice about eating and drinking.

We observed the lunchtime meal in both the Old Hall and Liddell wings. People who required help with their meals received this assistance. The dining experience in the Old Hall was orderly and cheerful. One member of staff ate with the residents and chatted to them for the duration of the meal. However, on the Liddell unit we found that the lunchtime experience for some people was rushed due to one staff member having to support one person with their meal and supervise others during this process.

We saw this staff member sit by a person and prompt them to eat their meal. This person took a mouthful on their own so the staff member went to assist another person. A further person then requested some salt and pepper so the staff member had to stop assisting the person with their food and find some salt and pepper. They then returned to the person they were supporting and helped them with their food. They spent a total of eight minutes doing this. They then noticed that the other person was not eating their food so sat with them to prompt them to eat. Improvements are therefore required to make sure that people consistently receive the help they need to eat their meals.

During our last inspection on 14 November 2015, we found that improvements were required to the environment to help people living with dementia orientate themselves. The provider wrote to us and told us that improvements had been made to the Dibben wing and we found this to be the case. Contrasting colours of toilet doors and handrails were in place to help people orientate themselves to these areas as were memory boxes outside their rooms. There were also sensory items and pictures on the walls that people could touch and feel or look at.

However, this improvement had not been extended to the Liddell wing in which people living with dementia also resided. Although colour contrasting had been used to help people orientate themselves to the toilet and to guide them along corridors, there was no signage in place to tell people where the communal areas were. There were some pictures on the walls but no memory boxes by their doors to help them orientate themselves back to their rooms. There were no items for people to pick up and amuse themselves with. We were advised by the staff that these items were being stored in an unused room within the unit.

There was also no secure outside space for people living in the home to access independently. We spoke to the regional manager about these concerns. They told us that plans were in place to improve the environment within the Liddell unit and to provide a secure outside place for people. Therefore, further improvements are required to the environment to make sure it is suitable for people living with dementia.

Records indicated that healthcare professionals were contacted in a timely manner to visit the home to ensure that people's healthcare needs were met. These included GPs, chiropodists and the dementia specialist team. People saw their dentist or optician when needed.

We recommend that the provider consults the latest guidance regarding a suitable environment for people living with dementia.

Requires Improvement

Is the service caring?

Our findings

All of the people and visiting relatives we spoke with told us that the staff were kind and caring. One person told us, "The staff here are quite pleasant, they have a job to do, but they are nice with it. They do treat me well and pop in and see if I need a drink." Another person said, "They look after me very well and they know my name. Everyone is very friendly." A visiting relative told us, "I think they [the staff] are very caring here." Another relative said, "The staff are brilliant."

When staff engaged with people, this was done in a polite and respectful manner. They referred to people by name and made eye contact with them when they were talking. The staff we spoke with demonstrated that they knew the people they cared for well. We saw some good examples of staff treating people with respect whilst showing them care and compassion. For example, one staff member was seen to comfort one person when they became upset. They held their hand and talked with them until they felt better. However, there was a lack of consistency in the caring approach of staff. They were not always available to intervene and offer reassurance promptly. Therefore, improvements were required within this area.

One staff member told us how they could not spend the time with people that they wanted. They explained that one person needed ten minutes spent with them before they went to sleep which helped them settle. They said however, that they were not always able to spend this time with them which resulted in the person having an unsettled night.

There were not always enough staff to make sure that people did not walk into other people's rooms and disturb their privacy. In one unit we heard a person call out that they needed a napkin when they had spilled a small amount of drink. We needed to draw this request to the attention of staff before they offered the person assistance. A few minutes later, the same person was calling out and distressed. We asked a staff member about this who said that the person did it a lot but did not intervene promptly to offer reassurance.

On another unit, we saw that one person had been positioned to the side of a lounge area. The television was on and we asked if they did not like to watch. They told us they did like to watch the television. However, they could not see it from their chair and they were unable to re-position themselves in front of the television. Another person was also positioned to the side of a television so they could not see the picture. They could not tell us if they wanted to watch the television but their care record indicated that this was an activity they enjoyed.

When speaking with one person in their room, they communicated to us that they wanted the television switched on within their room. However, they had no way of alerting the staff to this fact as the call bell was disconnected. We alerted a member of staff to this who dealt with the person's request.

The people we spoke with told us they could make decisions about their day to day care. One person told us, "Oh yes, I can make my own decisions, it is not a problem." Another person said, "I can sit where I want to." We observed the staff giving people choice about how they wanted to spend their day and what they wanted to eat and drink.

People's plans of care showed that, if they were able to, these were discussed with them. A staff member who was also a keyworker for one person, said that there was not much of a formal process for going through people's care plans with them regularly. However, they went on to say, "It's more about everyday choices and routines." They said they would discuss with people how they were and what they needed during the course of the day. They added that they felt the person would be able to understand the information at the time but possibly not retain it for long.

Some people, who were able to do so, had signed their care records to show they were involved in discussion about them. Relatives had also been involved in making decisions about their family member's care.

The staff we spoke with understood how to protect people's privacy and dignity. We observed that doors were closed when people received personal care and that people were appropriately covered when they were assisted to move with a hoist.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection on 14 November 2015, we found that the care being provided was not always focused or centred on the individual. We told the provider that this required improvement. During this inspection, we found that the necessary improvement had not been made. People did not always receive care that was responsive to their individual needs.

We received mixed views from people as to whether they received care based on their own needs and preferences. One person told us they were happy with the care they received and that they could get up and go to bed when they wanted to. They added, "I pick where I want to sit." However, another person told us they had requested a certain medicine to be given to them early in the morning. They explained that they needed the medicine to help them function and that as they did not get it when they wanted, they had to wait to start their day which they found frustrating.

Five staff we spoke with told us they could not always provide care to people based on their individual needs. Some staff said that there were not enough staff working in the morning, which affected their ability to help people get up in the morning when they wanted to.

During our observations we saw that three people were not washed and dressed at 10.30am. One person was not washed and dressed at 11am. We asked a staff member about this. They told us that they were not sure whether the person liked to be up early as it was not noted within their care record. They added however, that they knew the person used have an occupation which meant they rose early in the morning so felt that it was likely they would like to be washed and dressed early in the morning.

The staff told us that they could only offer people a bath once a week and could not meet people's preferences if they wanted a bath or shower more regularly than that. We checked three people's bathing preferences and records in relation to this. It was documented in two people's care records that they liked to have a bath, with one stating, '[Person] really enjoys a bath' but how often they wanted to have their baths was not noted. However, we noted that both these people had not received regular baths. During June 2016, one person had only received two baths and the other only one.

A lack of staff within the home meant that people's needs were not always responded to. When we walked onto one unit, a person told us they were thirsty and wanted a drink but there were no staff available to provide this. The person had to wait for the kitchen assistant to bring the tea trolley around and therefore did not get a drink when they wanted one. Another person on this wing caught the inspector's attention and told them that they were cold. The inspector therefore had to alert staff to this fact. One person was observed on another unit in the morning stating they were hungry. The staff were busy helping other people with personal care and therefore told the person they would have to wait until lunchtime for their meal.

We received mixed feedback from people about whether the activities on offer complemented their individual hobbies and interests. One person cheerfully told us, "I'm going along to see the music soon and they [the staff] are coming to get us and take us over. Not sure what the music is today, pop I think."

However, another person said they did not feel that the activities that were on offer reflected their individual interests. They said, "The activities that go on in this place no way reflect my needs. I'm not at the stage where I want to sing 'Down at the Old Bull & Bush' or be jigging about on the floor like a child in a group."

We saw that a staff member spent some time with one person going through a photo album. The person also had a watercolour picture on their table which we asked about. They said that they liked to paint when they were in the mood but added, "I don't get to do it as often as I would like."
Another person told us, "There isn't much to do here and the activities are a little boring, so much that I don't take part. I do have a brain and those activities aren't for me." They added, "I don't really go out as such because I don't think there is much opportunity to go out. Not sure if I'm up to it."

There were activities for people to participate in each day. These were held in the afternoon within a communal area of the home. On the first day of our inspection, a singer was visiting the home and we saw some people enjoying themselves singing and dancing to the music. On the second day of the inspection, Holy Communion was taking place. Some staff told us that other activities such as baking, drawing and visits into the community also occurred. However, not everyone within the home was either able or chose to participate in this activity. We observed that there was a lack of stimulation for these people.

We observed the activities coordinator spending some time with people on the various wings within the home. People were participating in some reminiscence looking at photographs of film stars from the past. However, we saw that on one wing, the activities coordinator was the only staff member available to support people and attend to their requests. They responded to one person's wish to go to their room by assisting them to do so, but this meant that they were not able to sustain people's interest and activities were interrupted. This affected one person who was offered a jigsaw and some photographs, both of which they picked up for a limited time. They lost interest when the activities coordinator was not able to sit and talk with them. We saw that they spent most of their time either walking up and down the corridor or sitting in the chair with their eyes closed.

The regional manager told us that the home had a vacancy for another activities co-ordinator as the previous staff member responsible for this had recently resigned. They added that staff also had a responsibility to engage people in activities that were meaningful to them and which complemented their hobbies and interests. However, although on occasions we saw staff spending time with people, most staff told us that they did not have time to engage with people unless they were performing a task. We observed this to be the case for the majority of the inspection.

People's care needs had been assessed before they moved into the home. However, although we noted that some people's preferences had been assessed such as their food likes and dislikes, not all preferences had been documented within their care records. For example, we did not see any information regarding what time people preferred to get up in the morning or go to bed. Only one person's care record indicated they liked to have male carers although we noted that there were no male carers working on the first day of the inspection.

Not all people's individual needs had comprehensive care plans to meet them in place. Therefore, staff did not always have clear guidance on what action they needed to take to support each person. For example, one person was diabetic. A care plan had been completed but this did not detail what action staff needed to take if the person became unwell or what healthcare support they required in relation to this condition. Another person had experienced a seizure but again, there was no information within their care plan to advise staff what action to take should they experience this again.

Some people's care records held inaccurate information. Therefore, there was a risk that the staff could provide the person with unsafe care. A member of staff told us that two people were receiving liquidised diets but their care records stated they had a soft diet. It was not stated in one person's care record they required full assistance to eat and drink safely.

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

We saw that written complaints had been fully investigated and that feedback had been given to the person who raised the concern. However, we received mixed feedback from some visiting relatives regarding whether their verbal complaints were responded to in a timely manner. One person told us, "I know my daughter has complained before and that it was sorted out." Their relative added, "I found the manager very understanding, kind and helpful over the issue which has resulted in them moving [family member] to another room today."

However, another relative told us that their verbal complaint had not yet been actioned. They told us, "[Family member] slipped in the shower the other week and although [family member] sustained no injury, the shower door got broken. As a result the bathroom keeps flooding. I told them it needs repairing because a wet flooded floor is dangerous, but [family member] is still waiting for it to be fixed for around two weeks." We asked a senior member of staff to look into this. They told us that this issue had been recorded in the maintenance book on 28 June 2016. They added however that they had been made aware that the issue had been reported prior to this but not actioned. Therefore improvements are required to make sure that all complaints are responded to and dealt with in a timely way.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection on 14 November 2015, the provider did not have effective systems in place to assess and monitor the quality of service that was being provided. This resulted in a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We asked the provider to make improvements within this area. The provider wrote to us and told us they would be meeting this regulation by end of May 2015. The provider had not made the required improvements. There continued to be a lack of effective systems in place to assess and monitor the quality of care being provided.

We again found concerns within some of the areas that we had previously identified during the last inspection in November 2014. These were having an impact on the quality and safety of care that some people who lived at Bilney Hall received. We also found other concerns during this visit. There were in relation to the management of people's medicines where they were given to them covertly, staff supervision and recruitment and the management of risk in relation to the premises and people's individual safety. The provider had therefore failed to make the improvements that were required since our last inspection.

We asked the regional manager to send us all of the audits that the home had conducted in May 2016. Only two audits in respect of medicine management were provided to us. No other audits were provided. We also asked for the last audits that had been conducted by the provider. Three were sent to us, which had been completed in November 2015, February 2016 and April 2016. The audit from April 2016 identified a number of areas that required improvement. For example that improvements to the environment were needed for people living with dementia. However, a senior member of staff told us that they could not find any evidence to suggest that action had been taken to improve these areas.

The regional manager was asked how they monitored staffing levels. They told us that it was the registered manager's responsibility to monitor staffing levels and to make any necessary changes. The regional manager could not provide us with any evidence to demonstrate that this had taken place. The provider placed people at risk of receiving poor quality and unsafe care as the required staffing levels within the home had not been met on a regular basis.

The provider's audits had failed to identify the potential risk to people's safety posed by exposed hot surfaces such as radiators. Although their audit in April 2016 looked at risks associated with the premises, it did not cover hot surfaces. A risk assessment regarding this area had only been conducted in June 2016 following an incident that had occurred within the home in May 2016, with remedial action planned to commence in July 2016. This did not robustly reflect all the shortfalls we found in relation to hot surfaces and the use of portable heaters.

We noted that the audit from February 2016 had in fact been conducted by the local authority quality assurance team and not by the service itself. This audit had identified that the information within people's care records needed to be improved so that it was more person-centred. However, we found that the required improvements had not been made and that people's preferences were not always documented

within their care records.

There was a checklist in place that needed to be completed to make sure that the required recruitment checks had taken place. However, we saw that this had not been completed as far back as February 2016. The provider's audit in April 2016 had a question regarding recruitment processes but this had not been looked at during this audit and had been left blank. This audit also stated that there were no issues with staff supervision but we found that this had not been delivered in line with the provider's policy.

The last audit of people's care records had taken place in January 2016 and we saw that these records were reviewed on a monthly basis. However, this audit and the monthly reviews were ineffective as it they had not picked up some issues that we found during this inspection including: inconsistencies in relation to the application of the Mental Capacity Act 2005 when taking decisions on behalf of people who could not consent to them had not been identified; the unexplained bruising experienced by two people had not been robustly investigated;

We also found that risk assessments in relation to the storage of creams within their rooms were not being reviewed within the timescales recorded. For example, it stated on the risk assessment that it should be reviewed each month. However, one had not been reviewed since April 2016 and another not since March 2016 to make sure that the actions required to reduce this risk were appropriate. We also found that some people's care records contained inaccurate information. The necessary guidance for staff to follow when providing people with care was not always in place.

Some areas of the environment had been improved for people living with dementia following our last inspection of the home in November 2014. However, this had only occurred within one wing of the home. This learning had not extended to the other wing of the home where people living with dementia also resided. This had been identified in the provider's audit in April 2016 but action had not yet been taken to make the required improvements for the benefit of the people living within the home.

A weekly clinical risk management form was completed for all of the people living in the home. This was used to identify where people needed to be referred for specialist advice such as from a dietician or a district nurse. However, although we saw that this had occurred there was no mechanism in place to identify that people's risk of malnutrition had been calculated correctly and that actions had not been taken to mitigate this risk.

The regional manager told us that no survey to capture people's views on their care had been sent out within the last 12 months but that plans were in place for this to be issued shortly. A meeting of people who lived in the home and their relatives had been held in April 2016 to gain their feedback on the care provided. However, although we saw that some suggestions for improvement had been made, no action plan had been drawn up in respect of these. The regional manager told us there should have been an action plan. They could not confirm whether any required actions had been taken. Therefore, we could not ascertain whether people's feedback on the care they received was being listened to and changes implemented.

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

Most people who were able to provide us with feedback about their care and the relatives were happy with the care that was being provided by the staff at Bilney Hall, although they felt that some aspects required improving. People and relatives told us they found the staff approachable and that they could raise any concerns they had without hesitation.

The staff we spoke with said they could raise any concerns they had with the registered manager at any time and that they were always available to them when needed. They told us that the registered manager was approachable and listened to them. This demonstrated that the home had an 'open' door policy where people and staff could discuss issues with the registered manager.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment provided did not always meet people's needs and reflect their preferences. Not all people's preferences had been assessed and the care had not been designed with a view to achieve service users preferences and ensuring their needs were met. Regulation 9 (1) (3) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the Mental Capacity Act 2005 had not always been followed when providing care and treatment. Regulation 11 (1) (2) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way and action was not always taken to mitigate risks. Regulation 12 (1) (2) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The required checks had not been completed prior to staff working within the service. Regulation 19 (1) (a) (b) (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet people's needs and to keep them safe. Staff had not received appropriate support, training, professional development, supervision or appraisal as is necessary to carry out the duties they are employed to perform. Regulation 18 (1) and (2) (a).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes were not in place to assess, monitor, and improve the quality and safety of the care provided or to mitigate risks to people's safety. Feedback from relevant persons had not always been acted on and care practice had not always been evaluated or improved. Regulation 17 (1) (2) (a) (b) (c) (e) and (f).

The enforcement action we took:

We issued a warning notice to the provider and registered manager and told them they had to meet this regulation by 1 September 2016.