Care Quality Commission

Bickham House Trustees

Bickham House

Inspection report

Green Walk
Bowdon
Altrincham
Cheshire
WA14 2SN
Tel: 0161 928 2514
Website: http://www.bickhamhouse.org.uk/

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

We inspected Bickham House on 8 September 2015 and the inspection was unannounced. Our last inspection took place on 15 April 2014. At that time we found the service met the five standards we inspected against.

Bickham House is a large detached Victorian building which provides accommodation for up to 26 people. There were 22 people using the service at the time of the inspection. The home operates as a registered charity. All bedrooms are single rooms and there is a large and well-maintained garden. The house also has a large communal lounge area with separate dining room. Bickham House is situated in Bowdon, which is near Altrincham.

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

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe at the home. Staff could explain the different forms of abuse people may be vulnerable to and said they would report any concerns to the manager.

Recruitment processes were not robust as thorough checks to make sure staff were safe and suitable to work in the care sector were not always completed before staff started work and were not well documented. This was a breach of the Regulation relating to the safe care and treatment of people.

There were enough staff on duty to make sure people's care needs were met.

Staff told us they felt supported by the manager and that training opportunities were good. People and relatives we spoke with told us the staff were caring.

The home was well maintained and comfortably furnished. People's bedrooms were personalised and we found the home to be clean and tidy.

We saw people had access to a range of healthcare services, including GPs, district nurses and chiropodists which meant that people's holistic health care needs were met.

Although we found some good practice in the way medicines were managed, we did identify some issues with the storage of controlled drugs and recording of the application of topical creams and lotions. We also found that medicines at the home were not being audited regularly. This was a breach of the Regulation relating to the safe care and treatment of people.

On the day of our visit people looked well cared for. We observed staff speaking respectfully to people who used the service. Staff demonstrated they knew people's individual preferences and what they needed to do to meet people's care needs.

We found the service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS) and saw good practice in the way that people were supported to make decisions.

People told us they were happy with the meals. There was a choice available for each meal and the chef was knowledgeable about dietary preferences.

People told us they thought the staff were caring and that they promoted their dignity and privacy. We observed interactions between people and staff that were relaxed and friendly.

We looked at people's care files and daily records. Apart from two examples which we raised with the registered manager, all entries were written using positive language which demonstrated the staff respected the people they supported.

The service had implemented good practice in end of life care and had received positive feedback from families whose relatives had been cared for at the home at the end of their lives.

People's care plans included detailed personal histories and their likes and dislikes and this was used to plan their care. We saw examples of when people had requested changes to their care plans and the service had made this happen.

Activities were planned for the people using the service and we saw activities on the day of our inspection. People and their relatives told us they would like to do more activities, especially trips out of the home. We recommended that the service ask the people what type of meaningful and person-centred activities they wished to take part in and make provision for them.

We observed that the lunch meal was quiet and staff were focused on serving food and collecting plates rather than interacting with the people who were eating. We recommended that the service investigate ways of improving the dining experience for the people living in the home.

Although we saw some examples of dementia-friendly signage, we recommended that the service investigates and implements good practice in modern dementia care to improve the quality of life for those living with dementia.

Visitors told us they were always made to feel welcome and if they had any concerns or complaints they would feel able to take these up with the registered manager.

Summary of findings

We saw there were systems in place to monitor the quality of the service. When areas for improvement were identified action was taken to address them. People using the service were asked for their views at meetings and via questionnaires.

We found two breaches of regulations and 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.

Recruitment procedures were not robust and staff had been employed without their suitability being fully explored and documented.

The accommodation was spacious, well maintained, comfortably furnished and clean.

There were enough staff on duty to meet people's needs.

Medicines were not always well managed. Controlled drugs were not stored safely, the use of topical creams was not recorded and medicines were not audited.

Requires improvement

Is the service effective?
The service was effective.

We saw from the records staff had a programme of training and were trained to care and support people who used the service.

The service was meeting the legal requirements relating to Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

People were offered a variety and choice of meals and were happy with the quality.

Records showed people had regular access to healthcare professionals, such as GPs, opticians, district nurses and podiatrists.

Good

Is the service caring?
The service was caring.

People using the services and their relatives told us that staff were caring and we saw staff treating people in a dignified and compassionate way.

Care plans were easy to follow and contained information about people's life histories and personal preferences. This information was used by staff to provide person centred care.

Relatives told us they were made to feel welcome when they visited.

Good

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

People's health, care and support needs were assessed and individual choices and preferences were accommodated. Care plans were in place and had been reviewed on a monthly basis.

Requires improvement

Summary of findings

There was an activities programme in place and we saw people involved in activities during our visit, however, every person we spoke with said they wanted to do more activities.

We recommended that the service investigate ways to improve the dining experience for people using the service to promote social inclusion.

We saw from the records complaints were responded to appropriately and people were given information on how to make a complaint.

We recommended the service does more to improve the quality of life of those living with dementia.

Is the service well-led?
The service was well-led.

Good

People using the service felt confident to raise any concerns with the registered manager. Visitors and staff told us the registered manager was approachable.

People using the service were asked for their views about the service and for any improvements they thought could be made.

Audits were carried out to make sure the systems in place were working as they should be.

We saw national guidelines which encouraged and promoted good practice were used to plan care.

Bickham House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 September 2015 and was unannounced.

The inspection team consisted of two adult care 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. The expert by experience on this inspection had cared for an older relative.

Before the inspection we reviewed the information we held about the service. This included asking the Local Authority and Healthwatch Trafford for information. The Local Authority gave positive feedback about the person-centred nature of the home's care plans, the access people had to other support services and the end of life care provided. Healthwatch Trafford had no information about the service.

On the day of the inspection we spoke with six people who used the service, three people's relatives, three members of care staff, the chef, the registered manager and the deputy manager.

We spent time observing care in the lounge and dining room and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

We looked around the building including in bedrooms, bathrooms, the kitchen and in communal areas. We also spent time looking at records, which included four people's care records, three staff recruitment records and records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe. One person when asked if they felt safe said, “Yes, I think so. It’s as good as anywhere else I suppose,” and another person asked the same question said, “Yes, there’s a feeling that nobody is frightened of anything.” A third person told us, “I feel safe, I haven’t been concerned.”

We arrived at 9.15am and after a tour of the premises spoke with the registered manager and deputy manager who told us there were four care workers and a senior care worker on duty that morning. We looked at the rotas for the last four weeks saw that they were organised on a fixed four-weekly basis. Staff had regular shift patterns which were a mixture of day and night shifts, apart from one care worker who only did night shifts. This meant that staffing was consistent for the people using the service.

Staffing in the afternoon consisted of two care workers and a senior care worker. At night there were two care workers plus a senior care worker who slept in an adjacent building and could be woken if support was needed. Two of the staff on duty had more than one role in the service, for example, one was a care worker and also worked as a cleaner and another was a care worker who had administrative duties. All care staff had responsibility for people’s laundry.

We asked the registered manager how having a fixed rota system allowed the service to meet people’s care needs if they increased, for example, if a person using the service needed end of life care. The registered manager said that the staff with more than one role could be asked to help provide care and that both she and the deputy manager were involved in the care of the people using the service.

We spoke with staff who told us they thought there were enough care workers to meet people’s needs although one worker said that covering staff sickness was sometimes an issue. Staff described how some workers had different roles on different shifts. Dual role staff worked according to the rota but could change roles if a need arose. This meant that the service could adapt to meet the needs of people if they changed.

People we spoke with and their relatives thought there were enough staff on duty to meet people’s needs. One person using the service said, “I’ve never felt there should be more staff.” The registered manager said that the home did not use agency staff at the home and covered sickness and annual leave by asking existing staff to do extra shifts. During the day of our inspection we observed that call buzzers were answered quickly and that there were enough care workers to meet people’s needs and keep them safe.

We asked what the rate of staff turnover was. One person using the service told us, “You do see a change and some are very good”, another said that they hadn’t noticed if care staff left and new ones were employed. The registered manager said that there had been some new staff employed in the last few months but that the core staff were stable.

We looked at the recruitment procedures in place to ensure only staff suitable to work in the caring profession were employed. When we checked the records for three members of staff we saw that two had a Disclosure and Barring Service (DBS) check. There was a record of their job interview and two written references were obtained before the staff started work. The DBS helps employers make safer recruitment decisions and helps to prevent unsuitable people from working with vulnerable groups.

However, we found a third member of staff had recently been employed as a care worker and was still awaiting the result of a check from the DBS. Bickham House’s recruitment policy states that until a DBS check is received care workers will always be accompanied by member of staff whilst at work. We saw from the rota that this care worker had already worked a night shift when there were only two care workers on duty. Putting a staff member without a DBS on a shift where there are only two care workers meant that the care worker had been put in a situation where they may have had to be alone with people who used the service.

The same member of staff had submitted an application form and CV for a care worker role with no work history prior to 2003 and a three year gap from 2009 to 2012. The interview for this care worker was not documented and there was no evidence that the registered manager had investigated the gaps in the care worker’s employment history. The lack of documentation meant it was not possible to evidence that the care worker had demonstrated adequate knowledge and was suitable for the role before being made an offer of employment. This meant thorough checks of people’s care practice and work history were not being undertaken to ensure they were suitable and safe to work with people who may be vulnerable.

Is the service safe?

The lack of interview documentation and investigation of gaps in work history of this care worker meant that the service could not be sure the care worker had the correct skills, competence and skills to provide safe care. This constituted a breach of Regulation 12 (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff disciplinary procedures were in place and we saw a documented example of how the disciplinary process had been followed where poor working practice had been identified. This helped to ensure standards were maintained and people were kept safe.

Staff we spoke with told us they had received training in safeguarding adults and were clear about how to recognise and report any suspicions of abuse. One care worker explained the forms of abuse that the people using the service could be vulnerable to and said, "It's important to make people feel safe". Another care worker said, "I treat every resident as a part of my family. I would report any carer behaving badly". All the staff we spoke with said that they would report any concerns to the registered manager.

Staff members we spoke with told us they had received fire safety training and we saw fire evacuation chairs located near the stairs in the home. Each person living at Bickham House had a Personal Emergency Evacuation Plan or PEEP in the emergency folder; it listed their name, age, mobility issues and room number. This meant that people could be safely evacuated in the event of an emergency.

During our inspection we looked at the systems in place for the receipt, storage and administration of medicines. We saw a monitored dosage system was used for some of the medicines with others supplied in boxes or bottles. The drugs trolley was stored appropriately when not in use.

We observed people were given their medicines in an efficient yet caring way and those who required more time or encouragement and support received it. This demonstrated people were receiving their medicines in a person-centred way and were not rushed.

We asked one person if they received their medicines on time and they told us, "Yes, first thing in the morning with breakfast".

We saw examples of good practice in the recording of medicines. Medication administration records for tablets and liquids were up to date with no gaps in recording. Staff recorded when people had refused medicines. As a reminder to staff there was a list of people who required time-specific medicines at the front of the medicines folder, plus details as to how each person liked to take their medicines and protocols for 'as required' medicines. 'As required' medicines are prescribed to be taken when a person feels they need them and a protocol explains the circumstances when they should be given, the dose and how often they can be taken.

There was a log of when 'as required' medicines had been given with times recorded to ensure they were not re-administered again too soon. We observed a senior care worker administering medicines using this system; they waited an extra five minutes to ensure a person did not get pain killers too soon after the last dose.

Agreements were in place with people's GPs so that the home could administer homely medicines when people needed them. Homely medicines include over the counter medicines such as paracetamol, laxatives and cough syrup. The home recorded when these medicines were needed and informed people's GPs if they were used for more than two days so that people's needs could be reviewed. This demonstrated that staff consulted doctors to ensure that people received the right medicines when they needed them.

We checked the arrangements for the storage and management of controlled drugs. Controlled drugs are prescription medicines controlled under Misuse of Drugs legislation and include medication such as morphine. We checked the stock of controlled drugs and found that it tallied with what was documented in the controlled drugs book. We also saw that two staff members checked in new supplies and recorded the administration of any controlled drugs. This meant that controlled drugs were managed safely.

However, we saw that controlled drugs were stored in a cabinet that did not meet the requirements of the Misuse of Drugs (Safe Custody) Regulations 1973. This meant that controlled drugs were not stored securely.

We saw creams and lotions stored in people's rooms did not have the date they were opened written on them; this is important as some medicines expire a certain time after they are opened. In one person's room we found a tube of prescription cream which had been prescribed for another

Is the service safe?

person and had a dispensing date of July 2014. This meant that the person may have been receiving a cream prescribed for someone else and was potentially out of date and could therefore cause them harm.

In the medicine cupboard we found a plastic tub containing seven tubes of pain killing gel which were prescribed for different people. The labels of two of the tubes had come off and most of the other labels were not well attached. By storing medicines for different people together, with poorly attached labels, there was a risk that people could have received pain killing gel that was not prescribed for them and could potentially cause them harm.

Prescribed creams and lotions were included on people's medicines administration records with body maps to show where they should be applied, but there was no system in place to record whether they had been applied. This meant that there was no way to check that people were receiving the creams and lotions they were prescribed by their GPs.

We asked how medicines were audited by the home. The deputy manager said that until April 2014 medicine stock levels for every person who used the service were checked weekly and documented and since then were checked monthly and not documented. Typical medicine audits involve the regular sampling of a selection of people's records to ensure that medicines are administered safely and correctly; this should then be documented. Lack of medicines audits meant that there was no way to be sure that each senior care worker was administering and recording medicines safely.

Although we saw some examples of good practice in medicines management at the home, the issues with topical creams, the controlled drugs cabinet and the lack of medicines audits constituted a breach of Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the day of our inspection we looked in people's bedrooms, in bathrooms, the kitchen and in communal areas and found Bickham House to be clean, tidy and odour-free.

We looked at the records for gas and electrical safety, for water testing and for fire and manual handling equipment checks. All the necessary inspections and checks were up to date and there was a system in place to ensure they were carried out at regular intervals.

Good

Is the service effective?

Our findings

Staff told us they received regular training. Records showed that staff had attended courses on safeguarding, fire safety, mental health and infection control. One staff member told us that they could request additional training if they wanted it. Staff had also received training in promoting the dignity of people using the service.

We spoke to a staff member about their induction and they told us they had shadowed another member of staff for 2 weeks and received practical and DVD-based training in addition and had also completed learning workbooks. The service had a dedicated training room in the annex to the main building. This showed us that the service provided training to ensure that its staff could meet the needs of the people using the service.

We found that care staff had received appraisals annually and also had regular supervision with either the registered manager or a senior care worker. Records of these meetings were detailed and comprehensive and included a discussion of individual staff needs and issues. This demonstrated that the home was supportive of staff's personal and professional development.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS protect the rights of people who are unable to make decisions for themselves.

Some of the people living at the home had complex health care needs that meant they required constant supervision or would be prevented from leaving unaccompanied, so applications for DoLS authorisations were necessary. We saw that all the correct assessments were in place for people who needed them and applications had been submitted to the Local Authority.

We saw examples of good practice as to how staff made and documented best interest decisions for people under the Mental Capacity Act 2005. This included the administration of medicines to people and decisions around DNACPR. DNACPR stands for 'do not attempt cardiopulmonary resuscitation' and means that if a person with this agreement in place has a cardiac arrest, staff will not attempt CPR. We saw that DNACPR best interest decisions for people who lacked capacity had involved them, their relatives, staff at the home and their GP. Best interest decisions for medicines administration involved people, their relatives and staff at the home. This demonstrated that the service promoted the best interests of people who lacked mental capacity to make their own decisions in line with government legislation and guidance.

We spoke to staff about their awareness of the Mental Capacity Act and DoLS. Staff could explain the requirements of the legislation and understood that capacity could fluctuate and was decision specific. In other words, they knew that a person could be supported to make decisions relating to their care, such as which activities to take part in or what to eat, but may not be able to make financial decisions or decide to leave the premises unaccompanied and that this could change depending on time of day and the mood of the person. This showed that staff were well trained and understood the needs of the people using the service in terms of their capacity to make decisions.

We asked people about the food that was served at the home. One person told us, "The food is very good, yesterday it was liver and onions and treacle tart. I enjoyed that". Another person said, "The food is perfectly alright, I have no complaints at all". A person eating lunch the day of our inspection said, "I really enjoyed that fish, it was lovely". One person did tell us, "You can get a dessert for your tea that could be running on for a week". Our expert by experience ate lunch with the people using the service. They thought the food was fine but did remark that the pudding was treacle tart, which according to one person was offered the day before.

By speaking with people and their relatives and making our own observations, we found that people were happy with the choice and quality of food served at the home. Trafford Council had carried out a food standards inspection in June 2015 and awarded the home a five star rating. This is the highest rating that can be awarded by Trafford Council environmental health officers.

The main meal of the day was served at lunchtime. People were given two choices the day before of main courses and two choices of dessert for their main meal but could change their minds if they didn't fancy what they had selected. Food was served from dishes on people's tables, therefore allowing people to serve themselves and take more if they wanted it. We saw one person who didn't want their main meal was offered alternatives by staff. When the

Is the service effective?

person apologised for not eating their main meal the care worker replied, “Oh don’t worry, it’s absolutely fine.” This meant that food choices were flexible and staff were happy to accommodate people if they changed their minds.

During the inspection we spoke with the chef and looked round the kitchen. We saw that information regarding nutritional risk assessment was displayed on the wall of the kitchen and the chef could describe how to meet the dietary needs of people with diabetes, cultural preferences and swallowing issues. The chef was also aware of the people using the service who had a lower body mass index (BMI) and said that an effort was made to provide these people with more of the foods they liked. BMI is calculated using a person’s height and weight and is a good indicator of whether someone is a healthy weight. This demonstrated that the service tried to accommodate individual people’s preferences and meet the dietary needs of the people at the home.

We saw from the care plans that the people using the service had access to a range of health care professionals. In the care plans we looked at we saw people had been visited by GPs, district nurses, opticians, chiropodists, audiologists, continence nurses and had also attended dental appointments. Visits were recorded in individual care files.

We spoke with people about their access to other health care professionals. One person said, “Yes, I could see my GP if I wanted to” and another said, “Yes, I do see the optician myself”. Another person told us they could see their GP when they wanted to and their relative who was visiting agreed. The relative also said the person saw a chiropodist regularly.

Good

Is the service caring?

Our findings

When asked if the staff were caring, people using the service told us, "I think so, I don't complain", and "Yes, they're quite decent". Another person, when asked if the staff looked after them well replied "I think they do, yes they do". Two people told us they could get up and go to bed when they wanted and another said "Well, I go when it's time to go, that's appropriate".

When we arrived some people were finishing their breakfast in the lounge area whilst others were drinking tea and reading the newspaper. The lounge area was large and traditionally furnished and had paintings and ornaments; it contained a TV, a piano and a computer with large keys. We asked care staff about the computer and were told that people could use it whenever they wished to search the internet or video call their relatives, with support from care staff if needed. There was a cat called Thomas who lived at the home; he slept in the lounge most of the day we were there. Shelves of books were also available for the people to choose from to borrow and read and we saw people reading books during the day of our inspection. After dinner we heard people being offered and accepting a glass of wine; we saw that people's alcohol preferences were documented in their care plans.

These observations showed us that the service tried to make Bickham House homely for the people that lived there and the people that we saw appeared relaxed and comfortable.

We looked at the care files for four people who used the service. They all contained life histories and their preferred daily routine, including which cups they liked to use, what films and books they enjoyed and the employment they had when younger. We saw people drinking from their preferred cups during our inspection. The home had a keyworker system, where members of care staff led on the care for specific people using the service. When we spoke to two care workers about people they were keyworkers for, they knew detailed information about the person's life history, their families and favourite activities. This showed us that staff knew the people using the service well as individuals.

During the inspection we observed care staff interacting with people using the service in a warm and friendly way. We saw one person ask a member of staff about a recent family wedding and another care worker compliment a person about a new item of clothing. This showed us that staff had formed caring relationships with the people that lived there.

We read the care files and daily care logs of four people who used the service. All of the entries written by care staff were done so respectfully apart from two entries which described people in a demeaning way. We raised this with the registered manager who agreed that the tone of the entries was not respectful; she said she would address this with the staff involved.

People living at the home were provided with information on advocacy services on admission and we saw referrals to advocacy services in people's care files. Advocacy services help people to access information, to make decisions and to speak out about issues that matter to them. Helping people to access advocates meant that the service was promoting their rights and independence.

We observed five people being assisted to move around the home by care workers. People were given clear instructions by the care staff while they were being assisted to walk or to sit or stand and were not rushed during manoeuvres. We did see one person who was watched by staff as they made several attempts to rise from a chair that was too low for them. When we spoke with two care staff they emphasised the importance of helping people to maintain their independence by giving time for people to stand and mobilise on their own.

Relatives told us, "The staff are extremely kind, attentive, and professional. They are very respectful of all the residents, keep them safe and encourage them", "They have bent over backwards to make [my relative's] life easier" and "The staff are very kind."

We spent time observing care in the lounge using the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We saw good interactions between people and care workers during which people's needs were met and they were spoken to with respect. Examples of good interactions included a care worker gently placing a blanket over a person who had fallen asleep in a chair and the patient and calm approach shown by a carer as they helped to escort a person to the toilet.

Good

Is the service caring?

When we looked in people's bedrooms we saw they had been personalised with pictures, ornaments and furnishings. Rooms were clean and tidy showing staff respected people's belongings.

Visiting relatives we spoke with told us they were always welcomed by friendly staff and were made drinks and offered snacks. One relative said, "I'm always incredibly welcomed yes. Today I was welcomed with this (cup of tea) and given a cake in the afternoon and another drink".

We wanted to find out how people had been involved in planning their care so we looked at four people's care files and spoke to people and their families about their care planning. Care files contained a detailed personal history and information on personal preferences and included a statement to confirm that the person had been involved in planning their care, signed by the person (if they were able to) and a relative. One relative told us, "I am always speaking to the staff, in constant informal discussions. I haven't checked [my relative's] care plan – I don't need to. The staff involve me well".

We noted examples of changes to care following feedback to the staff from the people using the service. For example, one person had requested to go back to their room after dinner on weeknights to watch soap operas, whereas another preferred to sit in the foyer of the house as it was quieter than the lounge. Another person did not like to sleep with their door shut so the service worked with their family to install a bedroom door that would shut if the fire alarm sounded, so that the person could have their door open at night and still be safe. This demonstrated that the service responded to people's preferences.

Each person also had a keyworker file, where the designated keyworker for that person documented the person's involvement in activities. The files were detailed and showed that people's personal preferences were used to plan and review the activities they took part in. This meant that people and their families were involved in planning care that was person-centred and individualised.

We asked people if they thought their privacy and dignity were promoted by care staff at the home. Two people said they thought that their privacy and dignity was promoted and a relative told us, "They always knock before coming in and wait for permission."

We saw that people looked well cared for. People were dressed in clean, well-fitting clothes and their hair had been brushed or combed. A hairdresser visited the home regularly and there was a salon equipped for their use. The deputy manager told us that people wishing to keep their existing hairdresser could also use the room on days the regular hairdresser was not there.

Bickham House is accredited on the Six Steps end of life care programme. The Six Steps is a programme of learning for care homes to develop awareness and knowledge of end of life care. End of life care relates to people who are approaching death; it should ensure that people live in as much comfort as possible until they die and can make choices about their care.

The home's end of life care policy was clear and well written and the deputy manager was the lead on this aspect of care. We looked at the care file of a deceased person who had received end of life care at the home; their care plans and risk assessments were detailed and appropriate and the person had signed to say they agreed with their plan of care. Documentation showed us that the home initiated dialogue with people and their relatives about end of life wishes in a sensitive yet informative way in advance of their requirement so that plans would be in place when the time came.

We read correspondence from relatives of people that had died at the home. One family gave thanks for the care that their relative had received, especially in their final days at the home. Another family thanked the home for a memory book that the staff had made for a long term resident who had died; their letter said that they "loved the memory book" and that it was "very special to them."

The end of life care planning records and feedback from relatives showed us that the home was committed to providing a good standard of care to those approaching the end of their lives.

Requires improvement

Is the service responsive?

Our findings

We looked at the care files of four people who used the service. We found the care files were easy to navigate and all followed a standardised format. The files contained detailed personal histories, information on personal preferences and their likes and dislikes. We saw good practice in risk assessment and care planning. People had detailed risk assessments and care plans for aspects such as moving and handling, communication, pressure area care, continence, mental health, falls and eating. We saw care plans were reviewed on a monthly basis to check if any change was needed to the way people's care and support was being delivered. This demonstrated that people's needs were being assessed and plans were put in pace to meet them.

Various aspects of people's care such as memory, personal care and mobility, had been incorporated into a dependency tool which was updated monthly. The more assistance a person required, the higher the score they were allocated; this allowed the service to track people's progress. We saw an example of this tool being used to trigger dialogue with a person and their family regarding Deprivation of Liberty Safeguards and end of life care when a decline in their ability was identified. The use of such a tool demonstrated that the service was responsive to changes in people's care needs.

Activities were advertised on the noticeboard in the lounge. These included a monthly quiz, a singer who came in every three months, a fortnightly arts and crafts session and a seated exercise session once a month. The home also produced a monthly newsletter called Bickham News. The September 2015 edition contained details on planned events and activities, sporting events that would be on TV, dates the hairdresser and religious representatives would be visiting the home and a 'residents revealed' section, where interesting facts from a person's life history were shared.

On the day of our inspection the home had a sing-a-long session in the afternoon and the monthly film and buffet night was held in the evening. The registered manager said that the people who used the service decided which films they wanted to watch and an informal sandwich buffet was served in the lounge.

People also had access to the large gardens, which had a vegetable garden and a summer house which had been decorated like a 1950s tea room. People using wheelchairs could not access the vegetable garden but could access the summer house and terraced patio area. The deputy manager described how staff brought freshly picked vegetables and flowers to the people who were unable to access the vegetable garden for them to hold and smell and also described how the fresh produce was used in meals at the home.

People we spoke with told us there were some activities on offer, such as singing, reading books and watching TV. One person described throwing balls to other people in the lounge area and playing skittles. A relative told us about an afternoon when various animals had been brought in for the people to touch and hold, they said "The one thing [my relative] does like is when animals come in and they can touch them". We saw photographs of people holding animals displayed on the lounge noticeboard and in people's keyworker files.

One person we spoke with when asked about the entertainment said, "There have been people entertaining, not very often nowadays. There was early on." Another said, "There's always that television on, too much reliance [is] put on the television. You see the television is on now but absolutely no one wants to listen to it!"

Three people we spoke with said they would like to do more activities, particularly trips outside the home. People told us, "Other places do trips and all that, they don't do all that", "I'd like to see more going on in the evening"; one person said "We all spend most of our time doing that" and pointed at other people who were asleep. Another person said they'd like to go to concerts. A relative told us, "Like most of the others here [my relative] would like to go out. That's one way in which [my relative] has been very deprived this year".

By talking with people and their relatives and observing the care provided at the home we saw that activities were available, but most people wanted to do more, especially trips outside the home.

We recommend that the service speaks with the people living at the home and their relatives to find out what types of meaningful and person-centred activities people would like to engage with and make provision for them.

Requires improvement

Is the service responsive?

Our observation of lunch showed that staff were focused on serving food and collecting plates, rather than on interacting with the people who were eating. There was also very little conversation between the people as they were eating. The lunch meal was not rushed and classical music was playing in the background. We observed one person ask the staff to turn the music down a little and this was done quickly, but we did not see whether the people eating in the dining room were asked if they wanted the radio on. Mealtimes present an important opportunity for people to develop and maintain relationships which can help to avoid social isolation. Guidance is available to help services promote a relaxed and sociable atmosphere and maximise people's dining experience.

We recommend that the service investigates good practice to improve the atmosphere at mealtimes in order to help people to develop and maintain relationships with others and to improve the dining experience.

Clear signage was used at the home to direct people to the nearest toilets; however, people's doors only had their names on and not photographs to help them find their way. There are ways to support people living with dementia in residential care, for example, the use of wall and floor colour to aid navigation and memory boxes to stimulate memory and promote discussion.

We recommend that the service explores good practice in modern dementia care, such as that produced by Skills for Care and the National Institute for Clinical Excellence, in order to improve the quality of life of those living with dementia.

People using the service and relatives told us they would feel able to raise any concerns or complaints with the registered manager or another member of staff. Relatives told us they found the staff and management approachable and helpful. One visitor completing a questionnaire about the response rate to complaints wrote that the service was, "Always positive and helpful."

The home had a complaints policy which people were reminded of at residents' meetings and a copy was attached to the inside of each person's wardrobe. Since our last inspection one complaint had been made by a person about another person using the service. We saw that the investigation and decision-making process was well documented and an outcome that was fair to both parties had been reached.

Good

Is the service well-led?

Our findings

We asked people about the atmosphere at the home. One person told us, “Can’t complain I suppose”, and another person said, “It’s quiet and you can talk to anybody”.

The registered manager had been in post at Bickham House since 2003. People’s relatives all knew who the registered manager was. The people using the service we spoke with felt confident that they could raise any problems or issues if they needed to with any of the staff.

We saw that the registered manager was visible around the building and that this helped them keep an overview of the day to day operation of the home. We noted their manner was informal and approachable and observed them chatting to people in a relaxed and familiar way.

There was an annual survey of people using the service. Results were compiled into a report which showed overall satisfaction in all aspects of the care provided. One person who had used the service for respite care and one visitor rated the home as either good or excellent for all aspects, including cleanliness, friendliness and helpfulness of staff. Another visitor described the home’s friendliness as, “Exceptional, I’m always greeted with a smile”.

The home held regular residents’ meetings for the people that used the service. The registered manager also told us that the monthly film and buffet night usually ended in a group discussion in which people shared their opinions about the service and gave feedback. Meeting minutes were available on the lounge noticeboard and copies were provided to each person. Topics discussed at the last meeting included the quality of the food served at the home and feedback on the activities provided. Holding residents’ meetings and using questionnaires shows that the service is seeking the opinions of the people living in the home in order to identify areas for improvement.

We asked people and their relatives if there were meetings held for relatives or if relatives had ever received a questionnaire from the home to find out what they thought about the care provided. People and their relatives told us that there were no relatives’ meetings and they had not received questionnaires. When we spoke with the registered manager they said that the home operated an open door policy whereby people who lived at the home or their relatives were encouraged to share any concerns or issues in person with them straightaway. The people we spoke with and their relatives said that they felt confident to raise any concerns with the registered manager and gave examples of when they had done so. The registered manager said that they would arrange a relatives’ meeting and consider using a relatives’ questionnaire to generate feedback on the service.

We looked at the minutes of the monthly staff meetings. Meetings included the discussion of relevant news stories, new legislation and home policies and procedures. Staff were encouraged to bring articles from scientific journals to share with other staff; for example, at a recent meeting the chef brought an article on food allergies. This was then stuck into the meeting minutes book for other staff to read. This meant that staff were encouraged to take part in professional development and to share knowledge with others.

Staff we spoke with said that the registered manager and deputy manager were approachable and supportive. One care worker told us, “The manager is very approachable”, another said, “Staff and the people in the home are like family to me”. This showed us there was an open culture at the home.

On the wall of the staff room we saw that all care, cleaning and kitchen staff working at the home had been involved in an ideas sharing exercise designed to create a quality environment at the home. Their ideas as to what made for a good care experience included, “A quiet, pleasant room”, “Providing dignity in care at all times”, “Unlimited visiting hours” and, “Personal items around the resident”. This showed that all staff at the home were involved in identifying good practice and areas for improvement in the care provided by the service.

We read the policies and procedures the home used to direct the service, for example, infection control and whistleblowing. They were all well written and several were in the process of being updated by the manager and deputy manager. This showed that the service reviewed their policies and procedures to make sure they were still fit for purpose.

A range of audits took place on a regular basis. These included audits of the environment, pressure area care equipment, fire safety and care plans. We saw when issues had been identified action had been taken to taken to resolve them. For example, when an audit identified a

Is the service well-led?

person had experienced a number of falls, they were provided with a sensor mat in their bedroom. Sensor mats alert staff when people get out of bed in the night and need assistance.

Bickham House operates as a registered charity. Four times a year trustee representatives make unannounced inspections of the home to speak with staff, assess the quality of care and check the premises. Reports are generated with action plans for any areas for improvement and these are shared with CQC; for example, the most recent inspection found that the service was finding it difficult recruiting new care staff via the local job centre, so the Trustees approved the use of an recruitment agency. This demonstrated that the registered provider took steps to audit the quality of care provided and supported the registered manager to make improvements.

We saw examples of good practice in the implementation of national guidelines and standards for end of life care and health and safety. Using guidance produced by bodies such as the National Institute for Clinical Excellence (NICE) and the Health and Safety Executive (HSE) allows services to be confident that the care they provide is up to date and evidence-based.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service could not be sure that a newly employed care worker had the skills, competence and experience to provide safe care. Regulation 12 (1) and (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines were not managed properly and safely. Regulation 12 (1) and (2) (g)