Four Seasons (DFK) Limited

Bickleigh Down Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 27 and 28 April 2016 and was unannounced.

Bickleigh Down Care Home (known as Bickleigh Down) is a purpose built nursing and residential home caring for a maximum of 77 people. At the time of the inspection 53 people were living at the service. Bickleigh Down is part of the corporate group Four Seasons (DFK) Ltd. The service is divided into five units, three nursing units and two residential units. Bickleigh Down provides care for older people who may have dementia and physical health needs.

Bickleigh Down Care Home was owned by Four Seasons (DFK) Ltd at the time of the inspection. The service had been sold to Harbour Healthcare Ltd. The new owners were in the process of registering as the new providers during the inspection process. This was due for completion at the end of May 2016.

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

We last inspected Bickleigh Down Care Home on 4, 5 and 6 March 2015. We asked the provider to take action to ensure the safe management of medicines and accurate records were kept. The provider sent us an action plan detailing the improvements they would make by the end July 2016. At this inspection we found improvements were still required.

Aspects of people's medicine management were not always safe. We found documentation and care plans did not always reflect what action was taken if people did not wish to take their medicines. We had concerns the procedures in line with the Mental Capacity Act (2005) were not always followed when people required their medicine covertly. Agency nurses did not always know the systems in place for medicine audits, ordering and emergency medicine which some people might require. This had meant some people had been without their medicine for a short period and there might have been a delay in receiving emergency medicine.

There were sufficient staff on duty to meet people's needs safely however, there was a high level of agency staff which particularly affected the dementia nursing units. This affected the leadership and continuity of care in these units. Agency staff were unfamiliar with the systems and processes on these units and did not know people well.

Essential work was reported promptly to the provider, but not completed in a timely way. This impacted on people's safety. For example there were problems with the call bell system and with one of the fire doors.

People's environment was clean and staff followed safe infection control procedures. However, there was a

strong smell of urine in the two dementia nursing units. This affected the carpets in the communal areas and some bedrooms. This had been reported to the provider and action had not been taken.

People had risk assessments in place to mitigate risks associated with living at the service however we found particularly on the nursing dementia units some of these had not been reviewed to reflect people's current care needs.

People's mental capacity had not always been assessed in line with the Mental Capacity Act (2005) as required. Applications to deprive people of their liberty had been submitted where required. However, some staff did not have a good understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). Further training was being arranged for staff following the inspection.

People were asked for their consent prior to being assisted; however some staff were unsure how to manage people who might decline personal care. This had led to the distress of one person. Staff told us they were keen to learn alternative ways to manage this and be creative in how personal care could be provided to meet people's individual needs.

People's nutritional and hydration needs were met, but the systems in place did not ensure people always had their preferences met. For example the current system used to deliver food to people from the kitchen to the dementia nursing units meant some people's choices were not always met as the food was plated up in the kitchen. Staff also told us evening tea was often before 5pm which meant there was a long gap between tea and breakfast. Although night snacks were available for those who were able to ask for these, many people on the dementia nursing units were unable to communicate if they might be hungry.

Staff were recruited safely. People were looked after by staff trained in many areas. Additional training needs identified during the inspection were promptly booked. People were protected by staff who could identify abuse and who would act to protect people. People told us they felt safe living at the service.
People told us staff were kind, caring and compassionate. Permanent staff and regular agency staff knew the people they care for. People knew how to raise a complaint if they had one and there were systems in place to investigate complaints.

There were activity coordinators and a range of social events to support people to remain active and stimulated. Arts and crafts, dressing up days and musical events were held at the service. People's faith needs were met.

People had their health needs met and saw their doctors, opticians and attended hospital appointments when required.
People were supported to maintain their independence for as long as possible. People told us personal care was provided in a way that maintained their dignity; staff knocked on doors before entering people's rooms, closed curtains and spoke to them and addressed them in the way they preferred.
We found breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were not always managed safely.

There were sufficient staff on duty to meet people's needs safely. However, there was a high level of agency staff usage which particularly affected the continuity of care for people living with dementia.
Essential maintenance work was reported promptly but not completed in a timely way which impacted on people's safety.
People's environment was clean and staff followed safe infection control procedures. However, there was a strong smell of urine in the two dementia nursing units.
People had risk assessments in place to help mitigate risks associated with living at the service. However; some risk assessments did not reflect people's current care needs which could place them at risk.
Staff were recruited safely.
People were protected by staff who could identify abuse and who would act to protect people.
People told us they felt safe living at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People were assessed in line with the Mental Capacity Act (2005) as required. Some staff did not understand the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS).

People were asked for their consent prior to receiving care. However, some staff were unsure how to manage people who might decline personal care.

People's nutritional and hydration needs were met but the systems in place needed to be improved to ensure people had a greater choice and that their preferences were met.

People were looked after by staff trained to meet their needs, other areas where staff required training were promptly booked during the inspection.

People had their health needs met.

Is the service caring?

Good

The service was caring.

People were looked after by staff that treated them with kindness and respect. People and visitors spoke highly of staff. Staff spoke about the people they were looking after with fondness.

People told us they were in control of their care and staff listened to them.

People said staff protected their dignity.

Staff sought people's advance choices and planned their end of life with them.

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not always have care plans and records in place which reflected their current needs.

Activities were provided to keep people physically, cognitively and socially active. People's religious needs were met.

People knew how to make a complaint. People's concerns were investigated and resolved promptly.

Is the service well-led?

Requires Improvement

The service was well-led by the registered manager.

Audits were in place to ensure the quality and safety of the service. However, identified issues had not been actioned in a timely way.

People were kept up to date on developments in the service and their opinion was requested.

People, relatives and staff spoke highly of the registered manager.

People and staff felt the registered manager was approachable. The registered manager had developed a culture which was open and inclusive. People and staff said they were able to

suggest new ideas for improvement.

There were contracts in place to ensure the equipment and building were maintained.

Bickleigh Down Care Home

Detailed findings

Background to this inspection

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

The inspection took place on the 27 and 28 April 2016. The first day of the inspection was unannounced.

The first day of the inspection consisted of a team which included one inspector for adult social care, a pharmacist inspector, two specialist advisors and an expert by experience. The second day the inspection team included an inspector for adult social care and two specialist advisors. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Specialist Advisors (SPA) are people employed by CQC with specialist knowledge in the area.

Prior to the inspection we reviewed the records held on the service. This included the Provider Information Return (PIR) which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed previous inspection reports and notifications. Notifications are specific events registered people have to tell us about by law.

During the inspection we spoke with 10 people and six relatives. We reviewed eight care records in detail and spoke to people where possible about their care. This was to check they were receiving their care as planned. We observed how staff interacted with people. We also spoke with 13 staff and reviewed nine personnel records and the training and supervision records for all staff. We spoke with the registered manager and a manager from another of the provider's services.

Other records we reviewed included the records held within the service to show the registered manager reviewed the quality of the service. This included a range of audits, complaints, thank you cards, minutes of meetings and policies and practices. We also reviewed the accident / incident system, maintenance requests.

Throughout the inspection we spent time on each of the five units (three nursing and two residential). We

looked around the premises and observed how staff interacted with people.

Before, during and after the inspection we spoke with the local authority quality team and during the inspection we spoke with four social workers.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection in March 2015 we found aspects of medicines management were not safe. We found there were problems with the storage and the recording of medicines. The provider sent us an action plan which included upgrading of dispensaries and a new ground floor dispensary. We were told a new medicine audit system; staff training and additional staff hours would be implemented to monitor this area. During this inspection we found some improvements in medicine management but continued to have concerns in some areas.

Although some ordering processes were in place to make sure that people had enough medicines, one person said "They keep running out of my night time medicines". This medicine was prescribed for pain relief and the person told us it left them in pain overnight. The manager told us that this prescription had been ordered from the GP but had not arrived before the weekend. The setting had not sought to clarify why the prescription had not been issued. This highlighted flaws in the processes used to ensure people received their medicines on time and as prescribed.

People were asked if they needed medicines that were prescribed to be taken when required (PRN), for example pain relief. Protocols were in place to give more information about when the medicines might be needed, the frequency of administration or the dose. This information was kept in the MAR folder. Some people on the two dementia nursing units did not always have their PRN medicine in stock. This unit had a high level of agency staff and stock checks did not identify when people's PRN was running low. This meant people went for a short period without the PRN medicine they had requested whilst new stock was ordered. We spoke to the registered manager during feedback and permanent staff were identified to carry out these audits to ensure sufficient medicines were in place at all times.

Registered nurses and trained care staff administered medicines to people living in the setting. One registered nurse was on duty in each nursing unit. Bickleigh Down used a high level of agency staff during the inspection. We spoke to one agency nurse about where people's emergency medicine was located. They took some time to find this medicine as they had not been shown where it was kept. In an emergency situation this could mean the person experienced a delay receiving the medicine they required. We spoke to the registered manager during feedback regarding the agency nurse induction and ensuring this essential information about people's medicine was incorporated into the agency nurse induction. Following the inspection clear signage was put in place for agency nurses to locate this medicine easily and additional information incorporated into handovers for new staff.

It was possible to check that oral medicines were given as prescribed because Medicines Administration Record (MAR) charts were completed following administration. However, the reason, date and time when people declined to take their medicines were not recorded. For example one person had not had antibiotics administered for two doses and no explanation was recorded. This meant their infection may not have been treated in line with advice from their doctor. Another person had declined to take one of their medicines on 29 occasions since 4 April 2016. This person's care plan showed their likelihood to decline medicines had been risk assessed on 6 December 2015 and 6 January 2016, with an action to report the

outcome on their MAR and in the daily notes. The care plan directed staff to report to the GP if medicines continued to be declined. However, only their MAR indicated this medicine had not been administered. There was no reference in their daily notes and no indication that the GP was contacted. This meant it was not always possible to identify a reason for ongoing refusal such as swallowing difficulties. In addition, it was not clear if the GP was aware or there was a plan in place to address this. It was not evident what the impact was of the person not having this medicine.

Care staff applied creams and other external medicines. Records were kept in people's rooms of which creams were applied and body maps were completed to show what area of the body they needed to be applied to. However, these records were not always fully completed. For example, one person had a cream that needed to be applied twice per day but the record chart only showed application in the morning. Another person had gaps which suggested that no cream had been applied. This meant it was not clear whether people were receiving their creams and other external medicines as prescribed by the GP, which could lead to a worsening of their skin condition. Body maps were often not reviewed or dated which meant monitoring the healing of people's skin condition was not possible.

Some people were prescribed pain relieving patches, which were prescribed to be applied once per week. The date and site of application was recorded but was not being rotated according to best practice. This meant that patches may be applied to the same area of the body. This can potentially cause more of the medicine to be absorbed into the body, which can lead to a risk of overdose.

Some people had information with their MAR charts to show they had their medicines mixed with food or drink and administered covertly (without their knowledge). There was no evidence in their care plans that the principles of the Mental Capacity Act (2005) had been adhered to or that a best interest process had been followed. One care plan contained an agreement from the GP on 23 September 2015 that that medicines could be given covertly. However, a statement on 23 October 2015 said that "xx has the right to refuse medicines". This contradicted advice from the GP regarding the cover agreement. Medicines that were crushed or mixed with food or drink had not been assessed by a pharmacist to ensure that this was suitable, meaning that the medicines might not work as well, or be given safely in this form.

People's care records contained information about their medicines and risk assessments but they did not always reflect what was happening in practice. For example, one person assessed as having low needs and being able to administer their own medicines, was having their medicine administered by staff. This highlighted a discrepancy in their level of need and could have meant they were not receiving the correct support to take medicines safely.

Medicine that required storage in a fridge was kept at temperatures that fell within the correct range however the temperatures were not recorded every day. This meant that although they were stored correctly it was not possible to audit this system to look for errors or discrepancies.

Medicines were not always managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Homely remedies (medicines that can be administered without being prescribed) were used in accordance with a signed and dated homely remedies list. Records were kept with people's MAR charts of all homely remedies given so it was possible to check how many doses had been taken.

Medicines were stored securely in trolleys and locked rooms with access to medicines controlled.

Medicines that require additional controls because of their potential for abuse were stored safely. Stock checks were completed daily and there were no discrepancies between the controlled drug register and actual controlled drugs in stock. Two staff administered and witnessed controlled drugs and both completed the entry into the controlled drug register.

Staff checked medicines received into the home to be sure that they were correct for each person.

Staff explained how they would deal with a medicines error and the manager explained how they were recorded, circulated and learned from.

Drug alerts were received and actioned as appropriate.

During previous inspections we noted areas of the home which were malodourous. The registered manager had reported these areas to senior management within Four Seasons and we raised this during our previous two inspections. We had been told the carpets in the communal areas upstairs on the dementia nursing units would be replaced. This had not been actioned and these areas continued to have an unpleasant odour. Many people on these units have continence needs. During the inspection one person was faecally incontinent on the carpet flooring and although this was promptly cleaned up, these carpet floorings remained unsuitable for these two units. Despite regular use of a carpet cleaner the odour on the two upstairs nursing units remained significant. The registered manager told us this was an area which would be highlighted to the new owners.

People had access to call bells and told us staff responded within five minutes however, during the inspection it was brought to our attention that there were two call bell systems and these were not linked. This meant if you were in the residential unit Torrs, Moorland View 1 or Moorland View 2 and pressed the emergency call bell it could not be heard by staff in the main part of the building. This affected 37 bedrooms. The registered manager told us people had fallen in the past and staff had needed to run and look for colleagues to request help because this problem had not been fixed. This problem meant there could be a delay in people receiving emergency assistance. The registered manager told us they had reported the issue to Four Seasons Health and Safety, the estates team and the regional manager many times over the past three years. The registered manager reported the new owners would be made aware of this safety issue.

We found one of the fire doors on the dementia nursing unit was damaged. The maintenance person and the registered manager had reported this to the provider but the door had not been replaced. Following the inspection we liaised with the fire safety officer who visited and issued an order on May 6 2016 to replace the door without further delay. We spoke to the provider on 11 May 2016 and the door had not yet been replaced but Four Seasons and the new owners were aware of the fire order.

We were informed by staff of a recent incident where the fire alarm had sounded, most likely triggered by a fault with the lift. The agency staff on duty had checked there was no obvious fire but had not called the fire department or sought advice to reset the alarm and turned off the fire alarm panel. This meant if there had been a fire that night there would have been no warning system. Following the inspection the registered manager told us all staff were receiving further training and knew to call the fire brigade immediately in the event of the fire alarm going off.

Not ensuring the equipment used by the service to ensure care provided remains safe and is used in a safe way and doing all that is reasonably possible to mitigate risk to people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Bickleigh Down had a Four Seasons (DFK) Ltd recording system for incident reporting called "Datix". We were informed only falls with injury were recorded. However, some staff recorded all incidents and others told us they only recorded incidents with injuries in accordance with the policy. This meant those people who were falling frequently without injury were not always identified. This meant there was the potential for care plans and associated risk assessments to be inaccurate for meeting a person's care needs. We spoke to the registered manager and following the inspection all incidents with or without injury were recorded to monitor trends and where possible reduce incidents such as falls.

Care records were not always reflective of the care people received. The system in place at the time of the inspection meant information was kept in several different places and the overview of people's care by the nurses was not always apparent. This was particularly an issue on the dementia nursing units where there was a high use of temporary staff and there were no unit managers in post. For example one person's assessment sheets until December 2015 stated they had not had any falls in the last 12 months. That monthly review showed they had more than 2 falls in the last 6 months, however the person's notes detailed 7 falls since 5 January 2016. The mobility care plan stated they should be encouraged to use their frame, but we observed the person not using the frame on several occasions and only saw staff taking the frame and encouraging the person to use it on one occasion. In March 2016 there was a comment that the person needed to wear appropriate footwear to minimise the risks of falls; however we saw they were in shapeless, soft slippers. There was no evidence to indicate the frequency of falls had been noted or information about what action was being taken to reduce the likelihood of the person falling. We raised this with the registered manager during feedback and this person's care was being reviewed during the inspection.

People's weight was monitored and weight loss (where noticed) was reported to people's GP. However on the dementia nursing units we found people , had lost weight over the previous months but there was no overview of this and care plans did not record the action had been taken where weight loss had been noted. We spoke to the registered manager about checking all of the people on these units to ensure any weight loss was being addressed. This was actioned following the inspection feedback and people's care was reviewed.

Assessments were in place to monitor the risk to people's skin. We found these were reviewed but were not always reviewed with people's current weight. Care plans did not always reflect the action being taken to reduce further weight loss. For example one person had an assessment in place from September 2015 when they were 60 kgs but their weight during the inspection had fallen to 53 kgs. We fed this back to the registered manager who planned to review this person's care.

We found people where required had pressure relieving equipment in place to reduce the risk of skin damage but on the dementia nursing units mattress settings were not always correctly aligned to people's weight. Following inspection feedback this was incorporated into the daily checks of bedrooms to ensure mattress settings reflected people's weight and therefore would be effective and help reduce the risk of skin damage.

Staff followed good infection control practices. We observed hand washing facilities were available for staff around the service. Staff were provided with gloves and aprons. Staff were trained to follow good infection control techniques. Staff explained the importance of good infection control practices and how they applied this in their work. The registered manager audit infection control twice a year and discussed the findings with staff. There were clear policies and practices in place and the registered manager ensured appropriate contracts were in place to remove clinical and domestic waste. The layout of the home and staff movement meant an outbreak of diarrhoea and vomiting had spread quickly across the service. The service sought advice and closed the units to reduce the risk of cross infection. We spoke to the registered manager about

not admitting people during these outbreaks in future and ensuring if they are transferred to hospital during an infection outbreak the receiving service is aware in order to minimise the risk of the infection spreading.

There were sufficient staff on duty to meet people's needs safely however the high use of agency staff affected continuity of care particularly on the dementia nursing units. There were two unit manager vacancies during the inspection which meant the leadership and overview in these units (Moorland View 1 and 2) was affected. Wherever possible the same agency staff were requested. A regular agency nurse working four days a week on Lee Moor and there was a permanent unit manager on the residential unit.

The registered manager had systems which were flexible to ensure staffing levels were maintained at a safe level in line with people's needs. People told us there were enough staff to keep them safe. Staff said there were enough staff for them to meet people's needs safely however we felt the lack of consistent staff on the dementia nursing units impacted on people receiving safe care. One person commented "Care staff are very, good, spot on, really good, but when you get Agency there is no continuity."

Recruitment of permanent nurses was an ongoing challenge at the home due to the location and poor public transport links. Recruitment days had been held with little success and the service was changing legal ownership and in the process of registering with CQC. Recruitment of nurses and the reduction of agency staff were a priority for the new owners. In the meantime the deputy manager was due to start working alongside the nurses to ensure care remained safe. However, they were also due to leave the service shortly. Staff told us "It feels safe but I don't like the level of agency nurses, we are in situation now where something has to happen." We were informed by staff the new owners were considering recruiting from abroad and providing accommodation to assist in the recruitment of registered nurses.

People felt safe living at Bickleigh Down Care Home. Comments included "I feel well looked after because the staff are so good and they are always around"; "The staff seem to know what they are doing and that makes me feel safe"; "They are always calling in to see if I'm alright or I need anything. The staff are excellent" and "I have my favourite staff that look after me. My girls are lovely. People felt comfortable speaking with staff and said staff would address any concerns they had about their safety. Visitors also felt it was a safe place for their family member to live. Staff said they kept people safe by "Regularly checking people to make sure they haven't fallen, make sure they can reach their drinks and I make sure they feel safe in themselves."

People were looked after by staff who understood how to identify abuse and what action to take if they had any concerns. Staff said they would listen to people or notice if people's physical presentation or emotions changed and that may be a sign something was wrong. Staff would pass on concerns to the registered manager. All staff felt action would be taken in respect of their concerns. Staff had undertaken training in keeping vulnerable adults safe. They told us they would take any concerns to external agencies, such as CQC, if they felt concerns were not being addressed.

Risk assessments were in place to support people to live safely at the service, those on the general nursing unit (Lee Moor) and the residential units (Torrs and Clearbrook), were in date. Where possible, people or those who mattered to them were involved in identifying their own risk and in reviewing their own risk assessments. Staff told us how they took time to get to know people to mitigate the risks people faced. Risk assessments were linked to people's care plans on these units.

Personal Evacuation Plans (PEEPs) were in place and the provider had a clear contingency plan in place to ensure people were kept safe in the event of a fire or other emergency. Risk assessments were in place to ensure people were safe when moving around the inside and outside of the building. Key pads across the

home helped keep people safe. These prevented unwanted people entering the building, and those who might be at risk when going out without a member of staff were also protected by these.

Staff were recruited safely. The registered manager and Four Seasons (DFK) Ltd ensured staff had the necessary checks in place to work with vulnerable people before they started in their role. All prospective staff completed an application and interview. Staff said the recruitment of new staff was thorough. Prospective staff's attitude and values were assessed alongside any previous experience. New staff underwent a probationary period to ensure they continued to be suitable to carry out their role.

Requires Improvement

Is the service effective?

Our findings

At the time of the inspection the high use of agency staff meant some staff did not always receive an induction. This meant some agency staff did not know the procedures which should be followed. This was particularly an issue if there were knew agency staff at the week end. We spoke with the registered manager who told us they would take action to make improvements.

New permanent staff underwent an induction when they started to work at the service. Progress was reviewed to offer support and advice as required and staff appointed in the previous year told us they had felt supported during this period.

Staff told us they felt trained to carry out their role effectively. The registered manager had systems in place to ensure all staff were trained in the areas identified by the provider as mandatory subjects. This included first aid; fire safety; manual handling; safeguarding vulnerable adults; infection control and food safety. Staff were trained in areas to meet specific needs of people living at the service. For example, training in supporting people with dementia and continence care. Training was regularly reviewed for all staff to ensure they were having the training essential to their role. For example, all activity coordinators had training in meeting the needs of people living with dementia and making activities personalised to people's cognitive needs.

Staff were also being supported to gain qualifications in health and social care. Staff had regular appraisals and observations of their competency to ensure they continued to be effective in their role. Individual and group supervision was offered for any staff that required it and any staff performance concerns were reviewed by the registered manager and /or unit managers and registered nurses.

The service had introduced the Care Certificate and one care staff proudly told us they were a "Champion" in this area and were due to attend training imminently to support their colleagues. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

We checked whether the service was meeting the legal requirements of the Mental Capacity Act (2005). We observed some staff often giving people multiple choices which appeared to confuse them if they had cognitive needs. Staff had different approaches regarding personal care. For example, during the inspection one person had initially requested a bath, but had since changed their mind. They were very distressed they had a bath afterwards. We spoke to staff concerned about how they could approach this in alternative particularly for those people who might change their mind and had fluctuating capacity. Staff were open to new ways of thinking to avoid the person who was resistant to personal care at times becoming distressed and were going to review their care in this area. We feedback the mixed understanding of some staff and further training was booked following the inspection.

Some staff were unclear about the MCA and DoLS, and staff did not understand why some people had DoLS applications in progress. We spoke to the registered manager about this; training was booked following the

inspection to support staff understanding. The registered manager understood the principles of the Mental Capacity Act (2005). 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. Records, in most cases, demonstrated MCA assessments were taking place as required. People who lacked capacity were encouraged to have a say in their care through an independent advocate where required or those with the legal authority to make decisions on their behalf. Staff ensured people's care was discussed with a range of professionals and the family where appropriate, this helped ensure decisions were made in the person's best interest.

We checked whether any conditions on authorisations to deprive a person of their liberty were being met. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had submitted applications for those who required these shortly before the inspection and these were being processed by the supervisory body.

Pictures and objects of interest on walls provided stimulation for people. People living with dementia were supported to move around the service by the use of clear signs. For example, clear notices with pictures were used to support people to live as independently as possible by encouraging them to locate the toilet and find key rooms such as the lounge, dining room or bedroom. We found some notice boards with information displayed to orientate people were sometimes not reflective of the current day, this was not helpful to people with dementia. We spoke to the registered manager about this.

People's lunch was brought to the dementia nursing unit via a "hot server". The food was plated and covered before leaving the kitchen. This meant there was no opportunity for people to regulate portion size or omit something they did not like. The food was served hot, but the food being served did not correspond to what was written on the menu board, this could be confusing and meant people were expecting something different.

People's likes and dislike were sought from them or from getting to know people.

However, the system of meals going to the dementia units upstairs meant people's preferences were sometimes lost in transit, for example one person did not like beans, but the plated meal had beans. The beans were removed when it was pointed out to them by the person.

People had access to drinks and snacks when required, although we found the range of snacks given to people could be expanded. For example, staff tended to offer biscuits whereas some people told us fruit would be nicer. Staff told us tea time was often at 4.30pm which meant there was a long gap until breakfast. Some people told us they "got peckish." The registered manager told us staff were able to access the kitchen overnight to make people snacks if they were hungry, but many people at Bickleigh Down were unable to verbally express to staff they might have been hungry due to the fact they were living with advanced dementia. We were told this was an area which would be looked into further.

People who could not help themselves were supported by staff to eat and drink regularly. We found some staff stood over people and the communication of some agency staff was not always age appropriate. We spoke to the registered manager about this staff member who had good intentions but whose language needing modifying.

There were set meal times and drinks rounds, people were encouraged to eat where and when they would

like. People were provided with food and drinks when desired although we saw one person requested a cup of tea and had to wait until the next tea round. The registered manager told us all staff could go to the kitchen and make someone a drink at any time.

The amount people ate and drank was recorded when necessary, but not always effectively monitored to make sure people's needs were being met. We spoke to the registered manager who told us it was the nurse's responsibility to monitor this but the desired goals for people were not always known or clearly recorded. The registered manager noted this as an area for immediate improvement.

People's special dietary needs were catered and people told us they tasted good. People could contribute ideas to the menu and there were choices available. We saw people who did not like the menu were given an alternative for example one person had scrambled eggs at their request.

People had their nutritional and hydration needs met and this was an area under review with the new chef. People and visitors were mostly positive and told us "All the food is absolutely fine and my cups of tea are always hot" ; "Mealtimes are ok, could be better with more choice"; "The food is so so, but it is always hot"; "I don't like what some things they serve so I buy some tins of soup and they heat it up for me in the kitchen"; "I would like to see them serve more vegetables"; "They know my wife can't eat rice but they still serve it her" and "The food always looks lovely and my relative eats everything."

People who were at risk of losing weight or whose nutritional needs had changed were referred for assessments with their consent, or in their best interests. Guidance given was then followed to support the individual person.

People had their healthcare needs met. People said they could see their GP and other healthcare staff as required. People added that this was always achieved without any delay. Records demonstrated people saw their GP, specialist nurses, opticians and dentists as necessary. People also had regular medicine and health assessments with their GP. Advice from professionals was clearly documented and linked to people's care plans to ensure continuity of care and treatment.

People's individual needs were met by adaptation, design and decor of the service. Areas of the service required redecoration. Staff had started this process themselves as they wanted to improve the interior décor for people. Colours known to provide a peaceful and calm atmosphere to people living with dementia and to reduce anxiety were being used.

Good

Is the service caring?

Our findings

Most people were very positive about the staff, their kindness and caring approach they demonstrated on a daily basis. Thank you letters from relatives reiterated this. People told us "Some staff are very good, but sometimes you ask for something and once they have gone out of the room they have forgotten"; "They let me have a shower after my tea so I then feel nice and relaxed before bed"; "All the management and staff are very helpful"; "I know that when I'm not here, I have complete peace of mind about my relatives care".

One person we met however told us night staff had told them not to use their call bell at night. We immediately discussed this with the registered manager who held a meeting to address this with the unit concerned and night checks were put in place.

The atmosphere in the service was calm and people were observed to be happy in the company of staff. People were encouraged to support each other and people were observed chatting easily with one another. We observed the staff supported people and each other throughout our time at the service. Care was given with gentleness, respect and in the person's own time.

People were supported at times of needing emotional support from staff. People who at times became agitated due to their health condition were supported by staff in a kind way. There was an understanding of the skills and interactions necessary to manage episodes of challenging behaviour, a staff member told me "It's about approach, the right attitude". Another staff member said "If someone is getting agitated I take them to somewhere quiet, find out what is wrong and offer them a cup of tea" We observed staff responding sensitively and calmly to people in distress, offering reassurance and demonstrating the ability to deescalate potential problems.
Staff showed a genuine interest and concern regarding people's wellbeing. Interactions between staff and people were spontaneous. Staff demonstrated a wish to provide supportive care whilst enabling independence when possible. An agency nurse commented "The senior carer is calm and gentle; he notices things and reports them to me immediately", "I have no issues with the care staff, they are a delight, they are hardworking, caring and perceptive."
Staff demonstrated an awareness of the importance of maintaining people's dignity. Incidents of incontinence were observed to be dealt with promptly, sensitively and discreetly.

All the staff talked about the people they were looking after with passion and caring. Staff described a strong ethos of care led by the registered manager.
One staff member told me "I try to care for residents in the manner I would like my own family cared for; if I do that I won't go far wrong. If someone puts their trust in me I have got to earn their respect and trust, knock on their door, not take away their last bit of independence."

Staff had an understanding of the people they cared for, there was an awareness of people's likes and dislikes and their lives prior to admission. Some of this information had been gained by speaking with people's relatives and friends. Life story booklets were present in people's care but, several had no entries and others had incomplete information. , The request for life story booklets to be located in people's rooms

was discussed and requested during the January 2016 at a staff meeting. This would enable staff who were working alongside people to note things which were important to people. However, this had not occurred. Care plans and personal information were kept securely locked in the offices to ensure confidentiality.

Visitors were seen coming and going throughout the time at the service and they were always greeted warmly by staff and by name. They were then updated on their family member's condition where appropriate. Visitors confirmed they were always welcomed and given refreshments regardless of the time of day.
People told us they were encouraged to remain as independent as they could for as long as possible. They confirmed staff always involved them in deciding how much they could do for themselves and staff would give them the time to complete this before fulfilling their task.

People told us staff protected their dignity at all times. We observed care in public areas were offered discreetly. The registered manager attended the local Dignity in Care Forum. They demonstrated they were actively involved in improving how people were cared for in their local area and their service. Care staff demonstrated a comprehensive understanding of the importance of showing respect and protecting the dignity of the people they cared for. One staff member told us "We take care to assist them to dress in the clothes they chose and help them with cleaning their teeth and brushing their hair". Staff members were observed knocking on people's door and waiting before entry. Choices around what time people wished to get up in the morning were given and respected. We observed care staff responding to people with spontaneous and warm interactions.

A "Staff Allocation" form had been recently introduced. This had been devised to help ensure that all people's care needs were met. The person in charge allocated the care duties for specific people during the shift and, although an approach task orientated in nature, the form also reminded staff of the importance of individualised care.
People's end of life was planned with them in advance where possible. People and those who mattered to them were encouraged to plan how and where they would like to end their life. Details were recorded about who they wanted to be with them. People were supported at their end of life to maintain their dignity and be pain free.

Requires Improvement

Is the service responsive?

Our findings

Records did not always demonstrate staff responding to people's needs as they occurred. Care records did not always reflect the care people received or the rationale behind decisions made. Gaps in people's care records made it difficult to evidence care provided, for example gaps in medicine records, observational checks and food and fluid charts. People's level of dependency was assessed but this did not always reflect their actual levels of dependency which meant they may not get the support they needed, particularly when staff who did not know them well were working on the unit. Care records were cumbersome to staff and information was kept in several different places which affected how quickly staff were able to access information and review care. It was not apparent care plans were a working document and maintained to reflect people's assessments of need. Staff relied on information on the handover "grab sheet" to provide care. This meant essential information may not be known by all staff providing people's care.

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

Prior to living at Bickleigh Down people's needs were carefully assessed to ensure the service could meet their needs. This helped ensure staff had the necessary details available to them to provide appropriate care as the person desired.

People had care plans in place which were personalised and reflected their current needs. Where we found discrepancies during the inspection these care plans were updated promptly. This was mostly on the dementia nursing units. Some people were familiar with their care plans and confirmed staff had discussed their care plan with them, others couldn't recall if this had occurred. Relatives we spoke with said they were involved with the care planning process and review. Staff told us they could suggest if they felt the care plans needed amending to ensure the care plans reflected people's most current needs.

People said staff would act promptly if they were unwell or had a concern; however one person told us they had waited a considerable length of time to see a dentist. We spoke with the registered manager about this, who told us they would speak with the person concerned.

Staff involved people and those who mattered to them in the decision making process where possible about how they wanted support or their needs met. All relatives said they were kept up to date and staff would call if there was an issue they needed to know about.

People were supported to maintain their faith and cultural identity. Faith leaders came to the service but people could also maintain their links with their chosen church or faith group. Staff discussed people's faith and cultural needs with them and every effort was made to ensure this was met.

People were provided with a range of opportunities to remain cognitively, physically and socially stimulated. People and visitors told us "I don't socialise much so I just stay in my room and watch television"; "I love quizzes so I really enjoy going to the quiz morning. It keeps my mind active"; "My relative loves to sit out in

the garden and watch the chickens. She knows all their names" and "I take my relative out for meals to a local café or restaurant for a change of scenery".

There were activities co-ordinators employed to provide a programme of events at the home aimed at supporting people to remain active. Planned activities were provided by staff and by entertainment coming into the home. For example we saw a harpist was booked and theatre and musical events were enjoyed. People were given a list of the activities in advance, although due to recruitment difficulties, staff said scheduled activities sometimes changed. People told us they could join in or not as they wished with the activities on offer. New ideas were discussed at team meetings and staff were encouraged to be as creative as possible and to offer variety. Staff were encouraged to sit and talk with people although we noticed some staff missed opportunities for engaging therapeutically with people.

People's concerns and complaints were acknowledged and investigated. People said they knew how to raise a complaint and felt comfortable speaking to the registered manager and other staff. The service had a complaints policy in place and complaints were inputted into an electronic system which helped to ensure people always received a response. All concerns and complaints were investigated and only closed once staff were assured the person was happy with the outcome.

An electronic computer tablet kept in the reception area meant people, visitors, professionals and staff could leave feedback at any time. The complaints process was kept in the reception area but we noted it required updating to reflect staffing changes at the service.

Requires Improvement

Is the service well-led?

Our findings

Bickleigh Down Care Home was owned by Four Seasons (DFK) Limited at the time of the inspection. The service had been sold to Harbour Healthcare Ltd and the new owners were in the process of registering as the new providers during the inspection process. This was due for completion in May 2016.

The registered manager and provider had a number of audits in place to help ensure the quality of the service. This included an infection control audit, audit of medicines, care plan audit and audit of accidents. Systems were in place to respond to feedback left by people. However, the inspection highlighted some areas were identified through the auditing systems, reported to the provider, but not always actioned in a timely way.

The registered manager had systems in place to ensure the building and equipment were safely maintained. The utilities were checked regularly to ensure they were safe. Essential checks such as that for legionnaires and of fire safety equipment took place. Internal maintenance processes were in place but there were delays in actions being implemented by the provider.

There was a senior management team to oversee the governance and leadership of the service. It was clear from records held within the service that the regional manager had taken a supportive and active role in auditing and assessing the service.

Comments about the leadership of the service from people, relatives and staff included, "All the girls seem to know what they have to do"; "Everybody in the home are excellent from the manager downwards"; "My relative has improved dramatically after having a stroke"; "The manager is very helpful and she pops into see how I am", "I went on holiday recently and it was nice to know my dad is in good hands", and "I've been here ten years and things have changed, but recently for the better. I enjoy working here."

People and visitors spoke positively about the registered manager. People and visitors felt comfortable approaching the registered manager. They felt any issues would be listened to and acted upon. People were encouraged to contribute ideas about how the service could be run. People and their families were able to feedback their views through an electronic system which was available at all times. People commented that their ideas were sought and put into action.

Staff confirmed they were able to raise concerns and agreed any concerns raised were dealt with immediately. Staff had a good understanding of their roles and responsibilities and said they were well supported by the registered manager. Staff told us the registered manager worked alongside them. Staff said there was good communication within the staff team and they all worked well together. Staff told us that they felt involved in the development of the service.

Staff confirmed they were supported and happy in their work commenting "I'm well supported by the home manager." Another staff member stated "Management are 100% supportive, Matron is fair with everyone, she has time for everyone and she leaves her door open for everyone".

A Bickleigh Down weekly Newsletter was distributed to staff. This helped ensure staff were kept updated with current information and changes. The newsletter included information on the introduction of a new admission and discharge checklist, reminders for staff to complete mandatory training and the opportunity to identify any equipment staff felt they may need to assist them in carrying out their roles.

The management team held regular staff meetings. The January 2016 staff meeting highlighted training courses available and discussed the new nursing revalidation process which helped keep registered nurses abreast of developments. A trained staff and senior care staff meeting was last held on 1 March 2016. The minutes that were documented included information on care plan audits and the planned introduction of homely remedies. It also included reminders to staff of their responsibilities to ensure the correct filling in of charts, and the encouragement for Registered Nurses to take responsibility for their shifts and to set good examples by working alongside care staff. These meetings kept communication lines open so staff were clear what was expected of them. These helped maintain the culture within the home.

The registered manager took an active role within the running of the home and had good knowledge of the people and the staff. There were clear lines of responsibility and accountability within the management structure of the company. The registered manager demonstrated they knew the details of the care provided to the people who showed they had regular contact with the people who used the service and the staff.

The registered manager knew how to notify the Care Quality Commission (CQC) of any significant events which occurred in line with their legal obligations. The registered manager demonstrated openness and transparency and they sought additional support if needed to help reduce the likelihood of the recurrence of any avoidable incidents.

The registered manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe Care and Treatment Regulation 12 (1) (2) (a) (b) (e)(g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not always safe. Medicines were not managed safely in all areas; risks were identified but timely action to mitigate risks to the health and safety of people were not consistently demonstrated. Fire equipment to keep people safe was not well maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Good Governance Regulation 17 (1)(c) Records were not accurate, complete and contemporaneous.