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Bath Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Bath Lodge Care Home is a small home which usually only accommodates up to 12 people with needs relating to old age. Five further beds are available which would only be used where people specifically wished to share. The service does not provide nursing care.

The service has a registered manager. 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.

The service provided safe and effective care. People felt they were listened to and could raise any concern they might have, with the management and it would be dealt with.

People's legal rights and freedom were protected by the staff. Staff looked after people's dignity in the course of providing their care.

People's health and dietary wellbeing were supported. Suitable activities were offered and people's spiritual needs were provided for. People could choose to what extent they were involved in group or individual activities.

Care plans were individualised and regularly reviewed, to provide staff with the information they needed to meet their needs.

The service had a robust recruitment process to help make sure that the staff recruited had the necessary skills and suitable approach to meet people's needs. Staff received appropriate training, ongoing support and supervision and felt their views about people's needs and the service itself were listened to.

The service was well led. It was monitored by the registered manager and registered provider who sought to constantly develop and improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were safe in the service. There were enough staff available, who were competent to provide the level of support each person needed.

The service had a robust recruitment process and records showed the required pre-employment checks had taken place.

Staff managed people's medicines safely on their behalf.

Is the service effective?

Good

The service was effective.

Staff received appropriate induction, training, supervision and support in the course of their work.

People's rights and freedom were protected and, where appropriate, others were involved in decision making about their care.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

It was evident that staff knew people well and were aware of their needs. Staff involved people in decisions about their care and offered enough support without taking over where people could manage things for themselves.

Staff worked calmly and patiently with people, giving them enough time to do things in a relaxed and unhurried way.

Staff ensured that people's dignity and privacy were respected.

Is the service responsive?

Good

The service was responsive.

Staff discussed and responded to people's changing needs on an ongoing basis.

Care plans provided appropriate detail about people's needs and preferences and were regularly reviewed to ensure they remained current.

People could take part in a range of activities in and outside the service and their spiritual needs were provided for.

Is the service well-led?

Good

The service was well led.

People praised the service and felt their views would be heard and acted upon. Staff and relatives felt their views were listened to.

The service was regularly monitored by the management who sought to make continuing improvements.

People's views about the service were sought via surveys and in resident's meetings.

Bath Lodge 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.

This inspection took place on 29 February and 2 March 2016 and was unannounced. This was a comprehensive inspection which was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR) which we received in January 2016. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help us plan the inspection. Prior to the inspection we reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

During the inspection we spoke with three staff and the registered manager. The service is registered for up to 17 people with needs arising from old age. However, because bedrooms would only be shared by specific request or consent, the usual maximum occupancy would be 12 people. People who use the service were able to give us some verbal feedback about their experience. We also observed the interactions between people and staff at various times throughout the inspection and had lunch with people on the first day to help us understand their experience. We observed how staff supported people in the service to meet their needs. We spoke with two relatives during the inspection and contacted a care manager to eek their views.

We reviewed the care plans and associated records for five of the people supported, including risk assessments and reviews, and related this to the care observed. We examined a sample of other records to do with the home's operation including staff records, complaints, surveys and various monitoring and audit tools. We looked at the recruitment records for two recently appointed staff.

Good

Is the service safe?

Our findings

Some people were able to tell us they felt safe. Two people told us: "I feel safe here" and one said they: "Always felt safe". From the reactions of others to the staff, people appeared relaxed and secure. It was evident staff knew people well and intervened promptly where anyone became anxious.

Relatives told us people were safe from harm and that staff knew people's needs very well. One said: "I am confident with [name] here" and another told us: "She is safe here and happy".

Staff had been trained and knew how to safeguard people from harm. All staff had attended safeguarding training and were aware of the different forms of potential abuse. Staff knew how to record and report any concerns or injuries. They knew where to find the contact numbers for the local authority to report a concern externally if necessary, and were aware of the whistle blowing procedure. Staff told us management would respond appropriately should any concerns arise.

One concern raised had not been reported to the Care Quality Commission at the time. However, all other appropriate actions had been completed at the time and a retrospective notification was made immediately after the inspection. The matter was closed by the local authority as it was unsubstantiated and the person returned to live at the service. Other issues and events had all been notified as required.

Appropriate individual risk assessments were carried out to safeguard people and staff within the service. Risk assessments were regularly reviewed. The service had a business continuity and emergency plan which provided staff with information about the steps to take and relevant contact numbers in the event of specific events. Routine servicing and safety checks had all been completed as required. Standards of hygiene throughout the home were good. A relative commented that: "There were no unpleasant odours". The kitchen had recently been awarded a five star rating by the environmental health department. An end of day security checklist was completed daily by staff to confirm they had ensured the building was secure. All exits were monitored externally by CCTV.

The service had a robust system of pre-employment checks to reduce the risk of employing staff unsuitable to work with vulnerable people. A full employment history was sought and any gaps were discussed with the applicant and the reason recorded. The recruitment records were comprehensive and included copies of references, evidence confirming identity and a criminal records check. Where staff were from outside the EU, checks had been made to confirm their right to work in the UK.

Staffing levels within the service were sufficient to meet people's needs. Two care staff were on duty throughout the waking day, supported by the registered manager during the daytime and people were supported by waking night staff. Staff turnover had been low and the only upcoming care hours vacancy was due to a change of someone's existing hours. The registered manager told us the service had not experienced recruitment problems.

The use of agency staff by the home had been limited. None had been used in the previous three months.

The registered manager preferred to cover shortfalls herself or from within the existing team, to maintain consistency. Where agency staff had been used in the past they tried to use one of three known individuals from a single agency. No evidence of their pre-employment checks, skills and qualifications had been provided by the employing agency. However, the manager obtained this during the inspection.

People were appropriately supported with their medicines because staff were trained and had their medicines management competency observed by the registered manager. The service had appropriate policies and procedures relating to medicines management. There had been no medicines error since the previous inspection. The registered manager told us there were no significant issues with medicines refusals and everyone could make it clear whether or not they were happy to take their prescribed medicines. As a matter of policy the home did not use night sedation. The registered manager's view was that the waking night staff were there to offer whatever support people needed, should they be restless or anxious at night.

The registered manager completed weekly medicines audits to check records for any errors or omissions. Medicines stock and returns were monitored monthly. Appropriate medicines records were in place, well maintained and provided an effective audit trail of medicines. Double signatories were obtained where necessary. People's medicines administration forms were accompanied by a photograph and details of any known allergies. Where people were prescribed PRN "as required", medicines, they had an individual protocol describing when and how these should be given. The most recent pharmacy audit found no significant issues.

Good

Is the service effective?

Our findings

Some people were able to give us verbal feedback about the support they received. One person said: "The people and staff are friendly". Another commented "Staff are always available if needed" but added that sometimes the speed of response to the call bell could vary: "If the staff are very busy". Another person said staff treated them well and were: "very good".

In addition, we observed the way people and staff related to each other to understand how people felt and how well the staff supported them. We saw staff supported people to make day-to-day decisions and they were encouraged to do as much as they could for themselves. Staff engaged well with people and offered assistance patiently, where it was required. People and staff also confirmed this was the case and care plans made reference to it. People's facial expressions and responses to staff suggested they had positive relationships with them. Staff did not take over and supported people to do things in their own time without being hurried. Some appropriate encouragement and prompting was offered to help people remain focused at times.

One relative told us: "It's really good here" and added they were: "Very impressed, [name] was well cared for". Another told us that: "Health care issues are followed up". Relatives were also happy they were kept informed about people's wellbeing. One said: "We are told how she is" and added: "She seems very settled".

Staff were provided with a documented induction to the service, based on the common induction standards and a programme of training with periodic updates. New staff shadowed experienced colleagues until they felt confident to work without direct supervision. Staff also confirmed that they worked alongside the registered manager on some shifts so had informal support and guidance freely available.

The training records provided, showed there was a rolling programme of core training. For example three staff were booked for an update to their safeguarding training with the local authority the week after the inspection and others were scheduled to attend over the next month. First aid training was also booked for eight staff in April 2016. No staff had yet commenced the 'care certificate' national qualification. The registered manager's training record highlighted where individual's training required refreshing and people were then booked to do these.

Staff attended supervision meetings approximately quarterly to discuss their work and training needs. One of these meetings was an annual appraisal to look at their ongoing development. Handovers took place between shifts to pass on key information and maintain continuity of care although these were not recorded. Staff could seek support outside office hours from the registered manager or from the provider, who lived on site

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

People were consulted and their consent was sought prior to the provision of day to day care or support. A 'consent to care' form was on each person's file, signed either by the person themselves or their representative. Where people were unable to give consent for more complex issues their representatives or family would be involved in 'best interests' discussions, for example around healthcare decisions. The registered manager was aware who had given power of attorney to others and this was recorded on people's files. Copies of power of attorney had been requested by the home.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made on behalf of six people, of which four were awaiting local authority assessment. The other five people were deemed to have day-to-day capacity.

People's general food and fluid intake was noted within monitoring charts to make sure overall consumption was appropriate and identify any developing concerns early on. People were also weighed monthly. No one was assessed as being at risk from dehydration or malnutrition, so more detailed records were not required. One person had their meal mashed/cut up by their choice to assist them to feed themselves. Adapted crockery and cutlery was available to assist people to continue to feed themselves where possible. The service's new cook was also a qualified nutritionist which the registered manager felt would help her ensure people had a balanced diet. The service had consulted with dietitians and the speech and language therapy team regarding swallowing issues in the past. A dietitian visited on the second day of the inspection in response to some potential concerns identified by staff around weight loss.

People were generally complimentary about the food although two felt that more choice might be nice. One person said: "The food is very good, I've no complaints". Another told us there was more choice in the past but: "Not so much now". One relative said: "The food is good" and: "She likes the food". They mentioned that people had a choice at breakfast and tea time. The staff knew people's likes and dislikes well. The lunchtime menu tended to reflect this but only one main meal was offered. The registered manager said that an alternative would be provided if staff knew the meal was not liked by someone, or if they asked. The possibility of actively asking if people were happy with the day's lunchtime meal was discussed, to enable an alternative to be offered. One person had suggested they might like the option of a curry or Chinese meal from time to time. The food we saw was well cooked and presented. The feedback about meals noted within service user meeting minutes was positive. People had previously been offered the chance to discuss the content of menus but it was minuted they had declined to be involved.

People felt the service looked after their health well. People's healthcare needs were well managed including needs around continence management. For example the service had successfully supported two people to regain continence following periods in hospital. Each person had a record of any health professionals visits on their file. The service consulted where necessary with external healthcare specialists. Some people used frames to assist them to mobilise and one person was transferred from place to place in a wheelchair. The home does not have a lift, and has only a stair lift on the main staircase. Bedrooms were either on the ground or first floor.

Good

Is the service caring?

Our findings

People were very happy with the caring and friendly approach of staff. Their comments included: "The staff are kind and respectful": "Very kind and gentle" and they: "Speak to me with respect". One person added: "They asked me about my getting up and bed times" and added: "They would listen if I wanted to change my bedtime".

Relatives had seen how staff supported people and said they were well cared for. They felt staff knew people well and people's wishes and preferences were respected. For example, people's choice to have their bedroom door open at night, which had been enabled. Relatives said people's spiritual needs would be provided for although their family member did not have that need. Relatives said they were kept informed of any changes in wellbeing.

We saw staff engaged well with people. They greeted people by name when they saw them and spoke reassuringly to them when they displayed confusion or anxiety. Staff responded patiently and gave people time to understand. They offered assistance where they could see someone was struggling, for example with their drink or meal. Staff gave us examples of how they gave people manageable choices such as between two favourite outfits, where they could not manage an entirely free choice. People's other choices were also respected wherever possible, for example about whether to have a light on at night. Staff demonstrated a detailed knowledge of each person in their discussions with us.

Relatives noted that whether people were being supported with personal care or healthcare, their dignity was maintained because this was always done in private in their bedroom. They said people's hair and fingernails were also cared for to help maintain their dignity through their appearance. The manager was also alert to maintaining people's dignity when a visiting health professional had failed to close a person's bedroom door. A visiting GP consulted people in private in their bedroom, with staff present if that was their wish. The service used GP's from four local practices which enabled a wide choice. Where possible, people retained their previous GP on admission.

We observed staff supporting people's dignity and privacy, ensuring that people's bedroom doors were closed when personal care was being provided. In some cases people were left to bathe themselves once they had been assisted into the bath. Alternatively people were encouraged to complete the personal care they were able to do for themselves with staff completing other tasks for them. Two people confirmed to us they did most of their own personal care. One said: "Staff let me do what I can". Staff talked about ensuring people remained as covered as possible, while being supported with personal care. They spoke discretely with people when checking thing such as their need for the toilet. They also referred to people by their preferred form of address. One person had a family nickname which staff also used appropriately. People each had their own bedroom and would only share a room if it was their specific choice, which also helped maximise their privacy and dignity.

At lunchtime we saw a staff member provided just the support one person required so they were able to continue feeding themselves, rather than taking over and doing it for them. They then sat beside another

person, who required more assistance, helping them with their meal, whilst offering appropriate prompts and encouragement to others. People were not rushed and could take their time to enjoy their meal.

The service had signed up to the local 'Dignity In Care' initiative and had used this to reinforce existing staff practice. Staff meeting minutes noted reminders to staff about maintaining people's dignity. People's files included information about their wishes, likes, dislikes and choices, to support staff to meet these. For example, people's preferred times to get up and go to bed, were noted as well as aspects of their care which they wished to do for themselves. Daily notes by the staff referred to people's self-care as well as using terms like "encouraged" and "supported".

The manager applied the principles of the "Gold Standard Framework" for end of life care. The views of people, and where appropriate, their families, were sought wherever possible, regarding their wishes for end of life and after-death care. The manager used a short leaflet on end of life care to introduce the topic. Staff had all received training on end of life care from the manager, apart from the most recently appointed care staff. Where people had not wished to discuss this element of their care, this too was respected.

Good

Is the service responsive?

Our findings

Relatives were happy that the service met people's needs. One said: "She seems very settled". People's care plans reflected their likes and preferences, and were supported by other relevant documents like risk assessments and any specialist healthcare advice obtained. They identified how people made choices and where and to what degree, they required support or could do things for themselves. Where people were able, the manager sat with them to discuss their care plan and assessment. Family were also involved or consulted where appropriate. The manager reviewed the care plans monthly to ensure they still met people's needs. People signed their care plans where they were able to do so.

Staff described how they responded to allow people more time if they did not want to be supported at the time offered. Staff would return later to offer support again or a different staff would approach them. They understood that at times particular staff might be preferred or have a positive relationship with people. We saw staff adopted a flexible approach depending on the person they were addressing and their mood and focus at the time.

The advice and support of external healthcare professionals had been sought where necessary including occupational therapists, community nurses, GPs and dietitians. A dietitian visited on the second day of the inspection in response to staff concerns about one person's weight loss.

A relative said: "They seem to lay on activities" and added: "[name] sings along with the songs during the singalongs". Relatives were also aware the service also had external entertainment from time to time. The registered manager told us they used the local library reminiscence service which provided themed suitcases of reminiscence items to stimulate conversation and discussion. The service also spoke individually with people and their families to obtain information about people's life histories to help staff engage with them and address meaningful topics. One person chose to spend their time in their bedroom and declined to take part in activities or eat meals with others and this was supported. They told us: "I choose not to take part in the activities". Others told us about the events and activities available and which ones they had enjoyed.

People could access a range of leisure activities. One person attended a day centre three times per week and went out with family most weekends. Others also went out with family and in one case, stayed overnight with them. Another person went to an outside craft session twice a month. People also chose to draw, do crosswords or puzzles and join in with a 'name that tune' game. The home had recently brought in an outside organisation with a collection of small animals for people to see and handle if they wished. Entertainers came in four times a year to sing songs and the service held parties twice a year as well as celebrating people's birthdays. People had decorated cupcakes and seasonal events were celebrated with associated activities.

The service provided for people's spiritual needs for example, through arranging visiting clergy. Two people regularly went out to places of worship with family. The registered manager said the staff would support this if family were unable to. In the past, the service had also met people's individual cultural and dietary needs,

including obtaining Halal meat. People's cultural or religious needs after death, had also been met.

The service had a complaints procedure which was posted in the entrance hall and provided to people in the service user guide. People were also told about it at admission. An informal comments book was located beside the visitor's book but no comments had been recorded. The complaints log was also empty. In discussion with the registered manager she gave examples of some matters which had arisen which were dealt with informally and resolved before they became a complaint. This demonstrated the service was responsive to people's views, although one example given could have been recorded as an informal complaint to demonstrate the process followed to address it.

People told us they knew how to complain and would do so if necessary. Where issues had arisen, people felt the service had listened and taken appropriate action. They felt any concerns would be listened to and acted upon. One person said: "I've not had any complaints". Another said: "I've never had a complaint, but they would deal with it if I did".

No concerns about the service had been reported to us by local authority care managers since the last inspection in September 2014.

Good

Is the service well-led?

Our findings

People were positive about the quality of the service and said they got on well with the registered manager and staff. Staff were also positive about the service's leadership and felt their opinions were sought and listened to. One told us: "They always ask our views by survey" and others confirmed this.

Bath Lodge care Home is a small service and the manager carried out a lot of informal monitoring by regularly working alongside staff on shift. This enabled her to oversee staff practice and see for herself where any problems or issues arose. It also meant she was a visible presence in the service and available for people or relatives to discuss any issues they may have. It was evident she knew people well and they knew her. Although the registered manager's office was on the second floor, she said she spent a significant portion of her day downstairs around the service, available, providing and observing care. Visiting healthcare professionals were familiar with her and had opportunities to discuss any concerns they might have.

The registered provider lives on site in a separate flat on the top floor and was therefore able to monitor the service's operation readily at any time as well as often being available on site in the event of any emergency. Both the registered provider and registered manager completed written records of periodic observations on the operation of the service, noting any issues for follow up. These records also provided evidence of flexible care and people's preferences being respected. For example, one noted several residents were still up watching TV at 10pm. Specific events were monitored such as accidents and incidents and action was taken where issues were identified. A health and safety audit form was completed monthly. Maintenance issues were reported to the maintenance man or external contractors as required. The registered manager had just implemented an updated quality assurance monitoring record to combine various monitoring into one document in order to identify emerging patterns or concerns promptly.

The registered manager was aware of the recent changes to regulations around duty of candour (openness when things have gone wrong) and the requirement to display the rating which would result from the inspection.

The provider did not have an overall service development plan as such but had a 'business continuity plan' in place. Regular informal discussions about the service took place between the registered manager and the registered provider. Staff meetings had taken place three times in 2015 and once so far in 2016. The minutes showed a range of relevant discussions about dignity, daily administrative tasks and people's changing needs. Staff felt there was as good team spirit and everyone pulled together and worked flexibly. Staff meetings were felt to be useful to maintain communication. Staff felt the management team conveyed clear expectations about the quality of care expected of them. One said the service was: "Always trying to develop and improve".

The service had recently issued a survey to people and relatives to seek their views about the care provided. Three positive responses had been received at the time of this inspection. The manager used a quarterly monitoring form to obtain people's feedback, which included questions about the meals and care provided. Previous feedback had been very positive. Comments had included: "I like the food here"; "I like living here"

and: "I'm happy with the help I get from staff".

Periodic residents meetings had also been held, most recently in October 2015, which included discussion about meals, activities and other subject related to people's experience of the service. The meetings were minuted. The minutes showed people had opportunities to ask questions or raise anything of concern and their views had been sought.