Methodist Homes

Stratton House

Inspection report

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Date of inspection visit:
28 January 2016

Date of publication:
23 March 2016

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

The inspection took place on 28 January 2016 and was unannounced. The care home was last inspected in September 2013 and met with legal requirements.

Stratton House is a care home registered to provide personal care for up to 33 people. There were 30 people living in the home on the day of our visit.

There was a registered manager in post. 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.

There were enough staff to meet people's needs. People felt safe and supported by staff. Staff were provided with regular supervision and training to help them meet the needs of the people living in the home.

People were cared for in a kind and respectful way. One person said, "They really care, nothing is too much trouble". Staff were polite and showed respect to people.

People were provided with a varied diet. The menus took into account the likes and dislikes of the people living in the home.

The registered manager understood their responsibilities with regard to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). This legislation is in place to protect the rights of people who lack capacity to make informed decisions, and to make sure people are only deprived of their liberty when it has been approved by an authorised body.

People's care plans were detailed and provided guidance about how to meet the people's care needs. The care plans provided detail about who had been involved. They were reviewed and updated regularly. This meant people's records contained up to date and relevant information about how to meet their assessed needs.

There was a system in place to check, monitor and improve the standards of care and the quality of the service. Audits demonstrated that regular checks were completed.

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 felt safe. Staff understood their responsibilities for keeping people safe from harm and abuse.

There were enough staff to meet people's needs.

The provider followed safe recruitment practices to ensure staff were suitable to work with vulnerable people.

There was a system in place to make sure people's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff received the training and support they needed to care for people effectively.

People had access to GPs and external healthcare professionals to ensure their health care needs were met.

People were supported to maintain their independence, and to eat and drink enough.

Is the service caring?

Good

The service was caring.

People were cared for in a kind and respectful way.

People's privacy was respected by the staff who supported them.

Is the service responsive?

Good

The service was responsive.

People were involved in the planning of their care. People's likes, dislikes and preferences were known by staff. Staff understood the needs of the people they were supporting.

People and their relatives were asked for their views of the service provided in annual surveys and at resident and relative meetings. Actions were taken in response to feedback received.

The provider had a complaints procedure in place. People knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

Systems were in place to monitor and improve the quality of the service provided.

Accidents and incidents were monitored and the provider analysed the information to ensure any trends were identified and lessons learnt.

People's views were sought and actions were taken in response to feedback received.

Staff were given the opportunity to provide feedback about their experiences of working in the home.

Stratton House

Detailed findings

Background to this inspection

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

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

Before our inspection, we reviewed the information we held about the service. This included statutory notifications. Notifications are information about specific important events the service is legally required to send to us. This enables us to ensure we address potential areas of concern.

During the inspection, we spoke with 10 people who used the service and one relative. We observed care and support provided to people.

We spoke with a senior manager, the registered manager, five staff, a member of staff providing support to one person by private arrangement and a volunteer. We looked at five care plans and various records and policies relating to the management and monitoring of the home.

Good

Is the service safe?

Our findings

All of the people we spoke with told us they felt safe in the home. One person told us they had an alarm to use if they went outdoors. The person told us, "If we go out into the garden alone, we have to pick up an alarm from the office".

There were enough staff on duty to keep people safe. One person commented, "There are enough staff on hand to help you if you need it". We spoke with the registered manager who told us they had recently increased the night staffing numbers. A dependency tool was used by the registered manager, as a guide to determining the staffing levels required. We checked the staff rotas and saw the staffing increase had been gradually introduced as additional staff were recruited. From observations we made during the day, there were enough staff on duty to care for the people in the home. We saw people were supported when needed. Staff were not rushed and responded promptly to people's calls for assistance.

Staff had received training and understood their responsibilities and the procedures in place for keeping people safe from abuse. Staff knew how to report safeguarding concerns to the registered manager or the provider. Contact details for the Commission and the local authority were available and displayed in the staff room.

Incidents and accidents were reported and actions were put into place when needed to make sure people were safe. The records we looked at provided clear details of actions taken at the time and as a follow up to make sure people were safe. For example, one person had fallen on more than one occasion. We saw the actions taken at the time. The person was seen by their GP. They were referred to a falls clinic and were provided with physiotherapy.

Risk assessments were completed, for example, for tissue viability, choking, mobility and maintaining a safe environment. The assessments were reviewed regularly and provided clear guidance for staff about the actions they needed to take to keep people safe. For example, for one person, in the safe environment section their care plan stated, "Make sure the hearing aid is working, ensure there is enough light in the room and ensure the floor is not a trip hazard". We saw this guidance was being followed.

We discussed a safety hazard on the first floor where the door opened directly onto a staircase which meant people could fall. The registered manager told us a risk assessment was in place but it needed updating. They contacted us following the inspection to confirm the risk assessment had been reviewed and they had amended the risk management plan.

Medicines were managed so people received them safely. People were given the opportunity to administer their own medicines. One person was able to do so safely. We saw staff followed safe procedures when giving medicines to people. Comments from people included, "My medication is given to me at 7.30am when I need it" and "They are given on time as far as possible". The staff knew what medicines people were receiving and the reasons why. People prescribed pain relief when they required it, were asked if it was needed. The medicine administration charts (MARs) were fully completed and staff signed for medicines

when they had seen people take them.

Equipment used to support people's care, for example hoists, was clean and maintenance service agreements were in place. People's rooms, bathrooms and communal areas were clean. One person told us, "It is all very clean here". The home had adequate stocks of personal protective equipment and staff used them to prevent the spread of infection. Checks were carried out to make sure electrical equipment was safe. Fire safety records showed that regular fire checks had been carried out to ensure fire safety equipment was in working order.

Emergency plans were in place that detailed the support people may need in the event of an emergency. Individual details were recorded in personal emergency evacuation plans (PEEPS). Staff read these to make sure they knew what to do in the event of an emergency situation.

Safe staff recruitment procedures were followed before new staff were appointed. Checks were completed to make sure staff were of good character and suitable for their role. Disclosure and Barring Service (DBS) checks were completed before staff started in their roles. The DBS ensures that people barred from working with certain groups of people such as vulnerable adults, are identified.

Good

Is the service effective?

Our findings

People told us that staff knew their needs and provided the care they required. One person said, "Yes, the staff know me quite well".

Staff were able to tell us about people's individual needs, preferences and routines. They explained how they kept up to date with people's current health care needs. They attended staff handovers between shifts, where information about changes, and updates in people's conditions, were discussed. Staff told us they also read the care plans regularly.

Staff told us about the supervision and training they received. One member of staff commented, "We are well supported. We are regularly supervised and discuss how we are doing. We discuss our weak points and our good points". Another member of staff said, "Staff morale was a bit low before Christmas because we were a bit short (of staff) and needed to use agency. It's much better now and we work well as a team". We saw records of staff supervision and training were maintained. Regular training updates were provided for topics such as moving and handling, first aid, infection control, fire safety, safeguarding people from abuse and equality and diversity were provided. The records showed staff had completed the training when required. Staff were supported with additional training in a variety of subjects to meet individual health needs. For example, four staff had completed training on Parkinson's disease. The district nurse had provided pressure ulcer awareness training for staff.

Staff had received training and demonstrated an understanding of the Mental Capacity Act 2005.
People were asked for consent before they received care and treatment. Staff knew that people had the right to refuse care and treatment. They told us they were not able to provide care unless a person had given consent. One person told us, "I feel I can say no to staff if I don't want them to give me certain care and treatment". Mental capacity assessments were completed. Where people lacked capacity to make decisions this was documented.

Best interest decisions were made for people, and we saw where the GP and people's families had been involved. The registered manager demonstrated a good understanding and we saw applications had been made in line with Deprivation of Liberty Safeguard (DoLS). These provide safeguards for people who may be restricted of their liberty for their own safety and only when it is in their best interest. The Commission had received notifications, as required by law, when people had DoLS authorisations in place.

People had access to healthcare services. Details of visits form external health professionals, for example the district nurses were documented in the care records. Where people had specific healthcare needs, regular monitoring took place and concerns were promptly reported to the GP. For example, we saw where one person had fallen, the GP was contacted and a referral made to the NHS falls clinic.

People were supported with fluids and diet to meet their individual needs. For example, people had been referred to speech and language therapy, and had softened food or thickened fluids prescribed when they were assessed as at risk of choking. People's weights were monitored regularly and actions taken if a person

had lost weight or was not eating well.

We received mixed feedback about the quality of the food and drinks served in the home. For example, one person commented, "Sometimes the food is all right". However, we received other comments such as, "The food is extremely good" "We have a choice of food", "We get a choice of what we want to drink at mealtimes and during the day" "Jugs of orange juice or whatever you like are changed once a day in our rooms and you can have a hot drink at 6am if you like" and "We went through a spell of hit and miss with the food but since last week, things are a lot better".

People chose their meal in advance, and were able to choose alternatives if they did not want one of the two main meals on the menu. The registered manager told us they had made some changes to the menu in response to feedback and comments from people.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion by staff. We heard a member of staff reassuring one person, "We're all here to help you. Just ask anyone and we'll help". On another occasion a member of staff held the lift door open, while a person walked towards it. The person responded, "Did you do that for me? How very kind". Other comments from people included, "The staff are all very kind and caring," "The carers are excellent, all of them. They really care, nothing is too much trouble. If they can't help, they get someone else to make it happen," "I have no complaints with privacy and dignity," "Generally staff are very kind. Staff are quite jolly" and "They (the staff) are so attentive, they're lovely". However, one person commented, "Most of the staff are compassionate although I do think sometimes there could be a bit more TLC (tender loving care). Sometimes staff don't recognise it takes people a while to answer a question. Some people take more time to digest it". The newly registered manager told us they would be spending more time on an individual basis with people. They told us they hoped this would encourage people to share any concerns they had.

Staff were observed communicating in a friendly and caring way and it was clear they knew people well. Throughout the inspection we overheard staff comments to people such as, "What are you doing today, you let me know when it's convenient for you and I'll come back" and "Would you like your manicure today".

Staff we spoke with understood people well. Details about people's lives were documented in the care records. Staff explained how they read people's care plans to also make sure they were up to date with people's current care needs. Our observations showed that staff understood individual needs and abilities of people and the level of support they needed to complete certain tasks. We saw that people were involved in making decisions about their care and independence was promoted. For example, one person with a visual impairment told us, "The staff help me with dressing, I do my own washing. They help me with the shower and they are very efficient". One member of staff commented, "We treat people how they wish to be treated" and "We want people to be happy living here".

Staff responded promptly when asked for help. We also saw examples of people's needs being anticipated by staff. For example, one person chose to stay in their room. We saw a member of staff 'pop in' just to check how they were. This was in addition to the planned care the person needed. The person told us they felt a bit lonely but they preferred to spend time in their room. The person told us staff popped in when they could just for a general chat.

Information about advocacy services was available in the reception area of the home. Advocacy services support people to have their views and wishes properly heard and acted upon when making decisions about their lives.

A chaplain provided guidance for staff with regard to providing emotional, spiritual and religious support for people when they were receiving end of life care.

Good

Is the service responsive?

Our findings

People spoke positively about the personalised care they received from staff. During the inspection staff were responsive to people's needs by ensuring they had the correct mobility aids as needed. Where required, staff responded to people's requests for help and support. People were asked where they would like to spend their day. We saw one person being helped to put on their outdoor clothes when they were going out to the garden for a walk. The staff member reminded the person to put on their hat as it was quite cold outside.

Care plans were person centred and contained information about people's lives before they moved into the home. People were assessed before they moved into the home to ensure their needs could be met. People and relatives where appropriate were involved in the planning and review of their care.

One person had spent time in hospital. When they returned their care plan stated, "Encourage to do as much as possible to promote their independence and to regain confidence". This showed the staff recognised and responded to the person's changed care needs.

Care plans were updated monthly and reviews were completed six monthly or more frequently if there were any significant changes in the person's condition. People, and their relatives where appropriate, were fully involved and where possible people had signed to confirm agreement with their care plans.

The care plans we looked at provided specific and up to date information and guidance about the current needs of the person. The care was implemented as documented. For example, one person had fallen on several times. A falls diary was completed. A falls intervention guide provided instructions for staff, "Remind to use zimmer, to use both hands and to look where they are going". The staff had identified that a contributory factor to the falls was a bag the person liked to carry while they were walking. Alternative arrangements were in place so the person did not need to carry their bag. We saw that where people had fallen, the GP was contacted. We saw referrals had been made to the falls clinic. One person had been referred for physiotherapy.

One person was assessed as being at high risk of developing pressure ulcers. The district nurse had provided support and guidance. The person was provided with a pressure relieving mattress and their position was changed two hourly. This was fully recorded. A chart to confirm the condition of the person's skin was completed on a regular basis.

However, we did note one occasion where the care practice was not in accordance with the changed needs of the person. The district nurse had provided support and additional equipment to meet the changed needs of the person. This had been documented by the district nurse. When we checked, the person was not sitting on the chair with the pressure relieving equipment provided by the district nurse. This meant the person was not being fully protected from the risks of becoming sore or developing tissue damage. This was brought to the attention of staff and the situation resolved promptly.

People received a copy of the activity programme on a weekly basis. We observed activities taking place during the afternoon of our visit. A volunteer supported staff with a group crossword game, which took place in the main lounge. People were positive about the activities that took place within the home. One person told us, "We have a reading group on a Monday and a Friday and various people come in to sing". Another person commented, "We play musical bingo, that is quite fun actually and people come in to sing to us. We get a weekly activity sheet, but I don't go out". Three people told us they would like the opportunity to go out more. They told us the cost of hiring a vehicle and paying for staff time was too expensive. The newly appointed registered manger told us they were planning to expand the activity programme.

A chaplain was available and provided support and services for people. The registered manager told us people living in the home were not expected to have any specific religious beliefs and this was explained to people before they moved into the home. However, prayers were routinely said before the main meal times in the dining room.

Staff were able to describe how they supported people's diversity to ensure people were not discriminated against if they did not share the views stated in the provider's mission statement. The mission was to "Improve the quality of life for older people, inspired by Christian concern". A member of staff gave an example of a person, no longer living in the care home who did not have Christian beliefs. Prior to the person moving into the home, the member of staff told us they had not been familiar with the person's beliefs. Their beliefs meant they had strong views about the way care was to be provided. The member of staff told us they received training and were able to successfully provide the care to meet the needs of the person.

People were given a copy of the information brochure for the home. In addition people were usually given a copy of the service user guide. This contained information about the organisation, and details about how to make a complaint. We were told by a senior manager the service user guide was being updated and was not currently available for people. One person commented, "We are supposed to have a handbook, it's been talked about for about six months now". However, people told us they received the information they needed about the home. People were confident they would be able to complain if they needed to. One person told us, "I would go to the office if I had a complaint, but I don't think I would have a problem here".

Good

Is the service well-led?

Our findings

People told us the registered manager was visible around the home. Comments such as, "Yes, I know who the manager is," "Yes I know the manager is (name of manager)" and "The manager has changed, but I know his face. He works hard and has a nice sense of humour".

Regular meetings were held with people and their relatives. A meeting had taken place in the week before our visit. Minutes of the meeting were circulated. We saw actions were being taken in reponse to issues identified. For example, a representative of the provider was providing support to the catering staff to resolve the issues people had raised.

People commented to us they had not raised some issues at group meetings. Some people said they had not been totally confident all issues would be acted upon. This included the provision of higher chairs for some people, the provision of a grab rail in one of the en suite shower rooms and the provision of a hand rail outside the front door. We spoke with the registered manager who told us they were looking at providing more opportunities for people to speak to them individually. They told us they wanted people to feel able to raise any concerns they had. They told us one of the actions they were taking was to be visible on a regular basis in the home. They told us they would actively encourage people to openly express any concerns or worries they had. They told us the hand rail was ordered but it had taken some while due to the specific needs of the building. They agreed they needed to ensure people received regular progress reports and updates for such matters.

The registered manager and staff were aware of the provider's values. They were all able to explain aspects of the vision, with words such as respect, dignity and improving people's quality of life. These values were all incorporated into the provider's values statement.

Staff told us they felt well supported by the registered manager. They had the opportunity to provide feedback at staff meetings, appraisals, supervisions and in annual surveys. The most recent survey showed overall improvements in key areas and there were areas for further development and improvement. The registered manager told us they wanted to provide more opportunities for communication with staff.

There was a range of quality monitoring and auditing systems in place. Checks were completed for medicines management, care records, incidents and accidents, weights, pressure area care and wellbeing. We saw the results of the systems in place were used to implement actions to improve the quality of the service for the people living in the home. Actions required were followed up to check they had been completed.

The registered manager promptly reported significant events to us, such as safety incidents. This showed they were meeting their responsibility as the registered manager.