Care Quality Commission

Bablake House Limited

Bablake House

Inspection report

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Coventry
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Tel: 01676523966

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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

This unannounced inspection took place on 10 May 2018.

Bablake House is a care home registered to provide personal care and accommodation for a maximum of 45 people, including people living with dementia. The home is located on the outskirts of Coventry and the accommodation is set out over two floors. There were 37 people living at the home at the time of our visit. This included eight people, on a short term basis who had been discharged from hospital for a period of assessment and re-enablement known as 'discharge to assess'.

The principle behind 'discharge to assess' is that people who no longer require care in hospital but are not yet able to return home, can be supported in a more appropriate setting such as a care home for a period of assessment and re-enablement before returning home.

People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At our last comprehensive inspection in April 2017 we rated the service as 'Requires Improvement'. This was because the service was not as responsive to people's needs as it should have been and was not consistently well led. For example, people did not always receive personalised care, staff were not always responsive to people's needs in a timely way and there was not enough for people to do during the day. Quality monitoring systems were not consistently robust and we had not been notified of all incidents we should have been told about. At this inspection we found improvements had been made and have rated the service as 'good'.

The service had a registered manager. This is a requirement of the provider's registration. 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 home provided safe care for people who lived at Bablake House. Staff understood what might constitute abuse and the action to take if they had any concerns. There were enough staff available to meet people's needs and staff were deployed effectively within the home. Staff understood risks related with people's care and knew how to manage risks to minimise harm. The suitability of staff was checked during recruitment procedures to make sure they were safe to work at the home. People's medicines were managed, stored and administered safely.

Staff had completed training in infection control and wore gloves and aprons when supporting people and carrying out their work to help prevent the spread of infection. The home was clean and tidy, there was

building work taking place but this did not impact on people's communal space.

People had an assessment completed before moving to the home to make sure staff could meet their care and support needs. Staff received training and had the knowledge and skills they needed to meet people's needs effectively. The registered manager and care staff understood the principles of the Mental Capacity Act (MCA) and how to put these into practice. Capacity assessments were completed and where required Deprivation of Liberties authorisations to keep people safe were in place. People's nutritional and healthcare needs were assessed and kept under review.

People were positive about the food provided and received diets to support their health conditions. People had sufficient to eat and drink during the day.

Some people at Bablake House were living with dementia, during our inspection visit we saw they looked contented and settled. People said staff were helpful and understanding, and we saw friendly and caring interactions between staff and the people they cared for. Staff maintained people's privacy, and treated people with dignity and respect.

The managers and staff had a good understanding of people's individual needs and preferences. People had a personalised care plans for staff to follow and staff were kept up to date about any changes in people's care.

The atmosphere in the home was friendly and homely, and care and support was provided in a person centred way. There were things for people to do during the day to keep them stimulated and occupied and visitors were welcome at the home. People knew how to complain if they needed to and complaints received had been responded to in a timely manner.

Since out last inspection the provider had increased the management of the home and employed a deputy manager. The registered manager told us this had improved the service people received as the responsibility of running the home was now shared. Care staff who worked permanently in the home told us there had been improvements since the changes in the management team. For example, they had more time to spend with people as staff were less focused on completing tasks. Staff felt supported by the registered manager and deputy manager, and were happy working at the home. The provider and management team checked the quality of the service people received and implemented improvements.

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.

Staff understood their responsibility to keep people safe and to report any suspected abuse. Staff understood the risks identified with people's care and knew how to support people safely. People felt safe with staff, and there were enough staff to provide the support people required. The provider checked the suitability of staff before they were able to work in people's homes. People who required support received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People had an assessment completed to make sure staff could meet their needs. Staff completed an induction and training to ensure they had the knowledge and skills to deliver safe and effective care to people. Where people lacked capacity, the registered manager and staff understood the principles of the Mental Capacity Act 2005 so people's rights were protected. People's nutritional needs and health needs were assessed and monitored to maintain people's health and wellbeing.

Is the service caring?

Good

The service was caring.

Staff demonstrated they cared about people and supported people with personal care in a way that maintained their privacy and dignity. Staff treated people with kindness and patience. People were supported to maintain relationships with those who were important to them.

Is the service responsive?

Good

The service was responsive.

People were satisfied with their care and knew how to raise complaints if they needed to. Staff knew people well, and each person had a personalised care plan that informed staff about their individual needs and preferences. People's care and

support needs were regularly reviewed and staff were kept up to date about changes in people's care. People were supported to participate in activities and follow their hobbies and interests.

Is the service well-led?

Good

The service was well led

The management team were committed to provide a quality service and there were processes to regularly review the quality of service people received. People were happy living at Bablake House and had opportunities to share their views of the home.

Care Quality Commission

Bablake 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 checked 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 comprehensive inspection took place on 10 May 2018 and was unannounced. The inspection was undertaken by two inspectors, a specialist advisor and an expert by experience. The specialist advisor was a registered nurse who was experienced in dementia care. The expert by experience was a person who had personal experience of caring for someone who had similar care needs.

We reviewed the information we held about the service. Since our last inspection we had received some concerns about the level of staffing and standard of care provided at the home. We referred the concerns to the local authority for investigation and reviewed the concerns during this inspection. We looked at information received from the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

Before the inspection visit, the provider completed a Provider Information Return (PIR). 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 were able to review the information in the PIR during our inspection visit. We found the information in the PIR was an accurate assessment of how the service operated.

During our inspection we spoke with the registered manager and deputy manager about their management of the home. We spoke with three care staff and four non-care staff about what it was like to work at Bablake House. We also spoke with three health care professionals who worked with people on short term assessment in the home.

Some people in the home were living with dementia and were not able to tell us in detail about their experience of living at the home. However people could tell us what it was like living at Bablake House.

During the inspection we spoke with six people who lived at the home and six relatives/visitors. We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time.

We reviewed four people's care plans, daily records and ten medication records to see how their care and treatment was planned and delivered. We looked at three staff recruitment files, staff training records, records of complaints and reviewed checks the registered manager and provider made to assure themselves people received a safe, effective quality service.

Good

Is the service safe?

Our findings

At our last inspection 'Safe' was rated 'Good'. At this inspection people who lived at Bablake House continued to receive good safe care.

People felt safe living at Bablake House and with the staff who looked after them. People told us, "I couldn't do without them, I feel safe", and, "I feel confident they can look after me here." A relative told us, "I feel [person] is safe here, the atmosphere is good." Another relative advised that they were "Happy as [person] had the freedom to roam around the house knowing they were safe."

Staff had received training so they understood what might constitute abuse and the action they should take if they had any concerns. Staff told us they would report any risks or harm to people's health or wellbeing to the registered manager. When we gave one member of staff a scenario of seeing another staff member roughly treating a person in the home they told us, "I have never seen that here. I might have to say something to them, but more than likely I would just go straight to the manager and report it." Staff told us they would not hesitate to escalate their concerns to a director of the provider company if they felt appropriate action had not been taken. One staff member commented, "I would have to go higher, to one of the directors and hopefully they would resolve it."

The provider used recognised risk assessment tools to identify risks to people's health, such as risks associated with skin damage, malnutrition, falls, and moving and handling. People's care plans were regularly reviewed and their risk assessment scores were updated when their needs and abilities changed. Plans to minimise risks took into account that people's abilities may fluctuate depending on their health on a particular day. For example, people diagnosed with Parkinson's disease. In one plan we saw the person was at risk of choking. Staff were advised to delay mealtimes if the person was particularly sleepy as it could increase their choking risk.

One person had to wear specialised pressure relieving boots and keep their feet raised due to risks of skin breakdown to their heels. We saw staff ensured the person was wearing their boots and had their feet raised during our inspection visit.

Where people needed special equipment such as airwave mattresses or pressure relieving cushions, we saw these were in place. When staff transferred people from a chair to their wheelchair they ensured their pressure relieving cushions were transferred with them. Pressure relieving mattresses need to be set at the correct weight setting for the person to reduce the risks of skin breakdown. Since the last inspection the registered manager had introduced a system to ensure mattresses were regularly checked and were at the correct setting to prevent the risk of skin damage.

A member of domestic staff understood their role in ensuring people's skin integrity was maintained and explained, "Crumbs in the bed, it could compromise the integrity of their skin."

People told us there was enough staff to provide the care and support they needed in a timely manner.

Comments included, "Yes, there is enough staff, you don't have to wait long for help." "There is always someone about," and, "Staffing has improved."

Staff told us they thought there were enough staff to support people safely. They told us they had time to spend with people without rushing. Care staff were supported by domestic staff and kitchen staff who provided additional 'eyes and ears' in the home to keep people safe.

However, there was a strong reliance on agency staff to cover staff vacancies on some shifts. The deputy manager explained, "I try to request the same agency staff so there is consistency of care because they know people's routines." They told us they had an on-going recruitment drive and agency usage had reduced in the last three months. A healthcare professional confirmed, "They have regular agency staff." On the day of our inspection visit, one member of staff had phoned in sick. The registered manager and deputy manager had both come in early to take responsibility for medicines and to support care staff to provide people with personal care.

People on 'discharge to assess' received additional support from healthcare professionals. This included a physiotherapist, occupational therapist (OT) and a technical instructor who visited the home daily to assess people's progress and provide rehabilitation for people. The health care professionals also had a presence in the home, and interacted with permanent residents. The registered manager told us, the OT and physiotherapist provided staff with guidance about using equipment to move people safely. During our inspection we observed staff using equipment to assist people to move, including a hoist. They carried out these procedures safely and confidently.

There were appropriate processes to ensure staff were recruited safely to the home. Staff recruitment files showed Disclosure and Barring Service (DBS) checks and written reference checks were obtained before people started work at the home. Staff confirmed this. The DBS assists employers by checking people's backgrounds for any criminal convictions to prevent unsuitable people from working with people who use services. A new member of staff confirmed they had to wait for their references and DBS to come through before they could start working in the home.

The provider's policies and procedures protected people from the risks of infection. The home was working towards an accreditation with the local authority 'Say no to infection' and the registered manager had appointed a champion to lead on infection control. We saw the home was clean and tidy. Personal protective equipment such as plastic gloves and aprons were available in the corridors of the home and there was hand gel at various places to prompt good hand hygiene. A visiting healthcare professional told us they had no concerns about the cleanliness of the home.

The provider had issued guidance to domestic staff about how to keep the home clean and hygienic. They had devised checklists for domestic staff to make sure every part of the home was regularly cleaned. Domestic staff told us they had all the equipment they required and were able to describe how they used different coloured mops for specific areas of the home such as bathrooms, kitchens and communal areas. They told us care staff informed them if anybody had any specific infections so they could take additional precautions when entering their bedroom, such as wearing plastic gloves and aprons and disposing of cloths they used straight away. One member of domestic staff explained, "You understand what poor infection control can do to people with diminished immune systems."

We spoke to a member of staff responsible for laundry. They told us about the system to ensure there was a clear pathway through from dirty to clean laundry to reduce the risk of cross infection and how they minimised handling soiled laundry.

Accidents and incidents were recorded by staff and information showed actions had been taken to address any injuries. The registered manager analysed these to identify if there was any action needed to prevent them happening again.

The provider had procedures to keep people safe in the event of an emergency which meant people had to be evacuated out of the home. Each person had a personal emergency evacuation plan (PEEP) and there was a summary of what assistance and equipment each person would need to evacuate the building, in the entrance to the home. There were evacuation chairs and sledges to support staff and the emergency services to evacuate people safely.

The provider had systems in place to make sure the premises remained safe for people, visitors and staff. Routine checks were made on the premises, including fire safety checks. Risks to the environment were mitigated because the provider used external contractors to check the safety of essential services such as gas and electricity. Equipment was also regularly checked to ensure it was safe to use. For example, hoists and bath chairs had been serviced in March and April 2018.

We looked at how medicines were managed in the home to make sure people received their medicines when needed and as prescribed. Only staff who had completed medication training, and were competent administered medicines. We found that medicines were stored, administered and ordered correctly.

However, we identified there were some improvements that could be made. For example, where staff had hand written information on medication records, this had not always been double signed as is recommended good practice. Patches prescribed for pain relief were being applied as prescribed but were not always being rotated in line with the manufacturer's guidance. One person had not received a prescribed medicine; the deputy manager had contacted the hospital consultant who had prescribed the medicine, who advised they wanted tests done before re- prescribing the medicine. However the tests had been delayed and the deputy manager had not discussed this with the consultant. The registered manager gave assurances these shortfalls would be immediately acted on and following our inspection sent confirmation they had been rectified.

The registered manager told us they monitored people's pain to ensure they received the most appropriate medication to control their pain. For example one person's health had declined and although they were on pain relief, they were still experiencing pain during personal care and having difficulties swallowing the pain relief medicine. This person was now on a pain relief patch and was no longer experiencing such high levels of pain.

We asked the registered manager about the use of antipsychotic medication often prescribed for people living with dementia who may become agitated or distressed. They told us only two people in the home were prescribed these medicines. One person was on a short stay basis and the clinical commissioning group (CCG) had responsibility for reviewing their medicines, the other was a permanent resident at the home. The registered manager told us, "I do not believe in medication to shut people up. We look at different ways to help people if they become distressed. They went on to say, "We have tried to move staff away from saying 'sit down, sit down'. We try to take people for a walk and keep them occupied; this helps with sleep and reduces behaviours that may challenge others."

Good

Is the service effective?

Our findings

At our last inspection we rated 'Effective' as 'Good'. At this inspection people at Bablake House continued to receive good effective care.

People and their relatives said they (or their family member) received effective care and support. One person told us, "I live here and I'm an old man; they look after me very well, I feel confident they know what they are doing." Relatives told us, "On the whole the carers are good," and, "They do things properly."

We looked at four people's care records. An assessment of people's care and support needs had been completed to ensure the person's needs could be met by staff. This included their physical, mental and social needs. Care plans had been developed from people's assessments. Plans included identified risks and informed staff what care and support people required and how they liked this carried out. People told us care staff knew what care and support they needed to meet their needs and maintain their welfare. Where possible people, or their relative had been involved in devising their care plans.

People told us they felt staff had the knowledge and skills to meet their needs. The general feedback from people was staff were, "well trained."

Staff received an induction when they first started working in the home and completed refresher training to keep their skills up to date. A staff member told us about their induction to the home. They said they had completed training and worked alongside more experienced staff. This staff member told us they felt confident to ask questions so they had a good understanding of their role. A staff training matrix showed staff completed essential training on an ongoing basis to ensure they had the knowledge and skills to care for people safely and appropriately. The managers monitored staff completion of training to ensure their skills were kept up-to-date.

During our observations we saw staff put their training into practice safely and effectively. For example, moving people safely using a hoist, promoting infection control by using protective gloves and aprons, and an awareness of dementia care in the way staff engaged and communicated with people. Staff confirmed they received regular training and additional training was available if they requested this. A staff member told us, "[Registered manager] does say come forward if you do want to go on any different training."

The home was working towards an accreditation with the local authority's 'React to Red' initiative to manage and minimise skin damage caused by reduced mobility. The registered manager had appointed a pressure ulcer prevention champion to help them work towards achieving this.

Staff attended individual meetings with the registered manager or deputy manager where they were able to discuss any training and development needs as well as staff performance issues.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity

Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The managers had a good understanding of MCA and how to put this into practice. People had capacity assessments completed when they moved to Bablake House which clearly identified where people required assistance to make decisions in their best interest and what decisions they could make for themselves. Where people required restrictions on their liberty to keep them safe from harm, for example, if they left the home alone, DoLS had been applied for and authorised.

Care staff received training to help them understand the MCA, and knew they should assume people had the capacity to make their own decisions. Staff knew the importance of obtaining people's consent and said they would speak with the managers if they had concerns about changes to a person's capacity to make decisions. During our inspection visit we saw staff routinely asked people for their consent before they carried out any tasks or care.

People who lived at the home, and visitors, told us the food provided was home cooked, good quality and that there was plenty of food and drinks available. One person said, "The food is good, and it's a balanced diet." During the day we saw people were regularly offered hot and cold drinks, which included a selection of milkshakes after lunch. Each time people had a drink they were also offered little additions such as biscuits, chocolate, or cakes.

We observed the main meal of the day which was served at lunch time and people were offered a choice. Staff knew people's preferences but said they still asked in case this had changed. All but one person in the dining room were able to eat independently. Staff were aware of people who needed some assistance to eat independently. For example we heard staff asking, "Do you need help cutting your meat?", "If you need any help, just let me know" and, "If it helps you, there is a spoon there for you." Staff were aware if people were not eating much and offered verbal prompts and encouragement to eat more. Drinks were regularly refreshed during the meal. The lunchtime meal was unhurried and people enjoyed their food. After lunch we heard one person commenting to a member of staff, "I like it because there's no cooking and no washing up."

The cook was aware of who needed special diets such as a soft, pureed or diabetic diet. One person had a specific diet to meet their cultural needs and we saw they were given a specially prepared meal at lunchtime. The cook was regularly updated about anybody who had lost weight so they could fortify their meals with extra calories.

One person at risk of choking was being given a soft diet until an assessment had been completed by the Speech and Language Therapist (SALT). The person told us, "They keep giving me mashed potato and I've told them, I do not like it". Whilst we were at the home, the SALT came to assess the person and made recommendations. We observed this information was immediately relayed to the cook and the person's nutritional details updated on their nutritional care plan so all staff were aware of the changes.

Peoples healthcare needs continued to be met by the home. People and visitors told us the GP, optician, chiropodist all visited the home. There was a sign displayed with the next date informing people when the audiologist would next be visiting the home to check for hearing loss.

The provider used recognised assessment tools to monitor people's weight and skin condition due to pressure. Any concerns were referred to the GP. The GP visited the home every week to see people who had

requested a visit or who were unwell. We saw from people's records and from observations during our visit that people had regular appointments with health professionals.

Each person had a 'hospital pack' which set out any risks to their health as well as information about their memory, understanding and nutritional needs. This was available if a person needed to be admitted to hospital as a prompt for healthcare professionals involved in the person's care.

The registered manager worked with other healthcare professionals to deliver effective care and support to people. We spoke with three members of the therapy team who visited the home to support the re-enablement of people in the discharge to assess beds. This included a physiotherapist, occupational therapist and technical instructor. They had a team approach to support people to regain functional activities and basic life tasks, such as getting washed and dressed and making their own drinks so they could return home. All three members of the team felt they, and the staff team at Bablake House, worked well together to ensure people made sufficient progress to return to their own homes. A therapist told us, "We have had some great results getting people home." And, "We have a good system and work well with the staff. We will even give advice about the permanent residents."

When a person had been discharged from hospital to the home for an assessment, their needs were assessed within 24 hours by the therapy team. They then informed Bablake House staff what help the person needed with mobilising, transferring and personal care. Staff were updated as and when people's needs changed so people gradually achieved independence in certain aspects of their care. A therapist told us, "We feed back to them what the person's goals are." When speaking about the home's staff the therapy team said, "They do support people well and will encourage them to be as independent as possible."

Since our last inspection in April 2017 changes had been made to the home environment. A lounge that was rarely used had been converted into two bedrooms and a shared bathroom. Building work was on going, and part of the home was inaccessible due to alterations to provide an additional lounge for people to use. A healthcare professional told us, "I don't feel it [building work] has made any disruption. They have managed it quite well."

There was an accessible garden with raised flower beds and places for people to sit and enjoy the warmer weather.

Good

Is the service caring?

Our findings

At our last inspection we rated 'Caring as 'good'. At this inspection people at Bablake House continued to receive a good caring service.

People and relatives told us staff were kind and caring. Relatives told us, "The staff are always attentive," "Staff are lovely and look after [name] well, and "The residents are well looked after and safe."

People appeared comfortable in staff presence, we observed many occasions when they were smiling and laughing together. We saw people enjoyed spending time in the communal areas for most of the day, watching others and talking with staff.

Staff were kind and compassionate in the way they interacted with people and frequently reassured people physically, by touching their arms and hands. For example one person was asleep and staff gently stroked their arm to wake them up without startling them when it was time for their lunch.

Staff seemed to genuinely care about the people they looked after. For example there were lots of times during our visit we observed care staff giving someone a hug or a kiss. One staff member told us, "I love it here."

Staff were attentive of people's needs. At lunch one person became upset. A staff member immediately responded and gave the person physical and verbal reassurance. Another member of staff told us, "I'm here for them [people] to get a smile makes the difference. It makes my day." We saw one person had been quite withdrawn and anxious at lunch time and declined to go to the dining room. Later during the day we saw a member of care staff sitting with this person playing a game of cards. The person was engaged, smiling and clearly responded positively to this one to one interaction.

There was information in people's care plans about their background and history so staff could get to know people. The registered manager had also started to introduce 'snap shots' outside people's bedroom doors which showed people's interests and what was important to people. This gave staff something to talk about with people which was meaningful and important to them.

Staff called people by their preferred names. For example, some people preferred to be called by their first name but staff respected that some people preferred to be addressed more formally. When staff gave people their meals they spoke to each person by name which gave people a sense of self-value and belonging.

Staff promoted people's privacy and dignity and were discrete when offering support with personal care. One visiting healthcare professional told us they had seen an occasion when the back of one person's dress was wet. A staff member noticed and immediately supported the person to change to maintain their dignity.

We observed staff use a hoist to move people. Staff were mindful of people's dignity when attaching the

straps and made sure clothing did not compromise people's dignity. During one procedure staff spoke reassuringly to the person, telling them how lovely they looked. The person told them, "I wasn't' scared at all." Staff ensured their clothing was adjusted before they went to the dining room.

The external therapy team told us, since they had started working in the home they had seen staff become more confident to encourage independence with people who lived permanently in the home. "They do encourage them to get up and move about. They are much more on board with encouraging people to mobilise." A member of non-care staff confirmed, "They (care staff) do encourage people more."

People looked clean and well presented on the day of our visit. A relative told us, there family member had been there for many years, and always looks clean and well- presented whenever they visited.

Relatives said they could visit at any time and were always made welcome. One relative told us how their family member used to be involved with the church and how the church had arranged to visit them monthly to give communion. They told us, "[Name] is content, and has no hankering to go anywhere else."

Good

Is the service responsive?

Our findings

At the last inspection we rated responsive as 'requires improvement' because people did not always receive a personalised responsive service. At this inspection we found improvements had been made and people received a Good responsive service.

For example, at the last inspection in April 2017 we found people did not always choose the times they got up or went to bed. At mealtimes staff seemed rushed and assisted more than one person to eat at the same time.
At this inspection improvements had been made in all areas where we had identified concerns.

At our last inspection we found staff did not respond to people's needs in a timely way, there was not always a member of staff in the lounge to respond to people's requests or needs and people said they expected to wait for support and they needed more staff. At this visit staff responded to people's needs promptly and there was staff presence in the lounge at all times during our visit. Staffing in the home remained the same as at our last inspection however, with the therapists supporting the people on discharge to assess, staff had more time to spend with people in the lounge. There was also an increased presence of non-care staff in the lounge area such as kitchen staff and domestic staff. There was a change in the ethos of the home as staff were less task focused and regularly engaged in conversations and activities with people.

The registered manager told us "There has been more engagement of staff with people, not just the care staff but kitchen and domestic staff who also spend time with people. There has been a change in focus of staff not to see things as a task but as an activity to include people in." We observed this taking place throughout our inspection visit.

In April 2017 people said they wanted more to do during the day as there was a lack of stimulation and activities. At this visit there was much more for people to do during the day. The deputy manager told us they had made improvements to the activities for people to be involved in to keep them occupied and stimulated. "People are here 24 hours a day and if there is nothing to do they become bored and un-stimulated. Relatives have noticed that their family members are now doing things, which they are pleased about."

There was something for people to do all day whilst we were there if they wished to join in. If not people were seen to be engaged with one to one or small group activities with staff. Where people did not want to join in activities they were watching what was going on or reading magazines and books. One person had taken responsibility for feeding the fish which they enjoyed. Care staff interacted with people in a caring and meaningful way.

There was an activity planner to inform people what daily activity was planned such as 'pat a pet', knitting, card games, exercise and visits by the hairdresser. Recent events included a special lunch for St George's Day, a trivia quiz about Wales for St David's Day, a Wild Bill Variety Show, a Wildlife Photo presentation, a music event and a visit from Zoolab with exotic animals.

Photo boards around the home displayed pictures of some of the events that had been organised this year with the people who lived at the home, staff and entertainers. Families were encouraged to join the events. The deputy manager spoke to people after the event to evaluate whether they had enjoyed them and whether they had been of value to them. They used this information to plan future events in the home.

A visiting healthcare professional told us the registered manager encouraged their staff to include everyone and support them to socialise. "They encourage everybody to go into the lounge so they don't get isolated. [Registered manager] is aware that if people are socially isolated, their mood will drop and they won't engage with the re-enablement." A member of non-care staff confirmed, "From what I see it is very good. Everybody is included if they are not interested in an activity, another is offered."

When we last visited Bablake House staff seemed rushed at mealtimes and assisted more than one person to eat at the same time. At this visit the meal at lunchtime was relaxed and unhurried. People who needed assistance to eat received individual attention from staff.

The care panning system was electronic and staff accessed care plans and completed the tasks people needed on their handsets. The management team were able to monitor that people had received the care and support they required, as a 'missed action' would alert them if this was overdue so they could take action.

Previously care plans were not person centred and there were no guidelines to inform staff how to support people who become anxious and distressed. We looked at four care plans. Plans were detailed and supported staff to provide individual care to people. Information about people's preferences and choices had been recorded and plans focused on the person and their needs and abilities. Care plans for people who lived permanently in the home were reviewed and updated monthly.

There were guidelines for staff to follow if a person became anxious or agitated. For example, one person had a DoLS in place because it was not safe for them to leave the home unaccompanied by staff. This person became anxious during the late afternoons and often tried to leave the home. Their care plan gave staff clear information about how they could improve this person's wellbeing and distract them from their behaviours so their anxiety was reduced. It read, "Staff need to make x feel wanted by encouraging him to do jobs such as collect cups or push the drinks trolley. X likes to make notes so staff to give pen and paper".

Staff knew the people who lived at the home very well and understood their likes and dislikes. At the front of each person's care plan was a snap shot of their basic needs and information about what was important to them. Staff could access this information at a glance on their handsets and use it to respond to people's immediate needs in a personalised way. The snapshot included any immediate risks to people's health and a summary of their care needs. It also contained information about their family and what they liked to talk about. For example one person's snapshot said they liked to talk about gardening, knitting and their family life.

Some people had agreed for a snapshot of their life history to be displayed outside their bedroom doors. The registered manager told us this supported staff to communicate more effectively with people as they could engage people in conversations about their past lives.

People's sensory needs were assessed and recorded in their care plans. This included what equipment they needed to enhance their ability to communicate. For example, whether they needed spectacles to read or hearing aids so they could better understand what was being said to them.

At the last inspection there was very little information about people on a short stay basis particularly around assessment and achieving goals. We saw this had improved. Short term care plans included goals and ongoing assessments. There were boards in people's rooms as an aide memoir for staff about the stage of the person's enablement. The deputy manager and therapists met weekly to discuss each person's development. The managers told us at least one of the therapists were there every day, including weekends.

People told us staff were responsive to people's needs. A relative told us their family member could no longer use a call bell when they needed assistance, so staff were always ' in and out' of their family members bedroom to make sure they were safe and comfortable. A visitor told us their friend had only been at the home for a few days. They said, "The carer's came to check on [name] every 30 minutes," whilst she was there. They told us their friend had remarked they were grateful for places like Bablake House to speed up their return home.

One person on a short stay basis told us as they were six feet tall the furniture in the home was not always suitable, "The commode, wheelchair and seat all seem to be made for shorter people." We discussed their comments with the registered manager who said they would speak with the OT about the equipment. This person was complimentary about the home and staff, and told us, "It's very well run", and had nothing but praise for the staff.

People were supported at the end of their life in the home. There was information in people's care plans about any decisions that had been taken about resuscitation should they have a cardiac arrest. The registered manager told us that once a person had been identified as being at end of life, a specific care plan was put in place so staff understood the care they needed.

The registered manager acknowledged they needed to seek people's views about how they would prefer their care to be delivered in their final days while they were still able to express them. For example; if the person wanted family present or any spiritual or faith support. They told us they planned to introduce an 'end of life' champion to lead on this piece of work to ensure people received the care at the end of their life they wished for.

The deputy manager told us they had received one formal complaint which had been recorded and responded to in line with the provider complaints policy. We looked at the complaints log which confirmed what the deputy manager had told us.

The deputy manager said people often raised minor concerns that they dealt with as they arose, but these were not recorded. Following discussion with the managers the registered manager told us they had put a 'concerns and niggles' book in place so they could ensure any concerns were dealt with before they became complaints and so they could monitor for any trends and patterns.

Good

Is the service well-led?

Our findings

At the last inspection we rated Well Led as requires improvement. At this inspection we found improvements had been made and people received a good well led service.

At the last inspection in April 2017 we found people did not always receive a consistently well led service. This was because we had not been notified of all incidents and events that had occurred in the home as required and quality monitoring systems were not always effective. We also found the service could be more dementia friendly. The registered manager had recently completed a diploma in dementia care but had been unable to implement changes due to lack of time and staffing.

At this inspection we found improvements had been made in all areas where we had identified concerns.

There was a registered manager in post who understood the responsibilities and the requirements of their registration. For example, they understood what statutory notifications were required to be sent to us, they had completed their provider information return when requested and the ratings from the last inspection were displayed in the home.

Since our last inspection the provider had appointed a deputy manager to support the registered manager in the effective running of the home. The registered manager told us, "Appointing [deputy manager] was like a breath of fresh air, I don't feel like we are standing still now. Things have improved and [deputy manager] makes my role easier." They went on to say the deputy manager was responsible for people's 'care' which allowed them (registered manager) to concentrate on initiatives and improvements in the home.

Staff also told us the change to the management team had been positive. One said, "Having a deputy manager has been great [name] is really approachable and gets things done." Another said, "Things have improved since you were last here. People have more to do, they are more relaxed and staff spend more time with people. The staff here now are really good, we are here for the residents not just because it's a job." Staff felt confident people received 'good' quality care.

The registered manager told us about the changes in supporting people in 'discharge to assess' beds. "At the last inspection staff were supporting people on short stay as well as permanent residents without external support. Having the three therapists to support people on re-enablement has made a huge difference and has meant staff now have time to spend with people."

We found since our last inspection in April 2017 there had been significant improvements to the home. For example, activities in the home had improved and people had more things to do during the day. Staff had time to spend with people engaging in conversation or individual activities. People's care plans had been reviewed and were detailed and more personalised. Staff morale had improved and an 'employee of the month' scheme had been introduced to acknowledge staff commitment and hard work. The registered manager said, "Staff work exceptionally hard, we are lucky to have such good staff, they are always willing to be flexible and cover shifts if we are short."

All the people living in the home and visitors to the home were very much aware of the manager and deputy. It was clear from observing interactions with people they had a good relationship and felt comfortable chatting with the managers.

Staff told us the registered manager was always available and willing to support them whenever a need arose. "I like [registered manager], she is very nice." "I love [registered manager]. She supports us. If we need help with one of the residents, she will be there and help us. She has no problems doing the washing up or sweeping up." "She is a very caring manager and tries and tries."

External healthcare professionals also spoke positively about the leadership shown by the registered manager, together with their knowledge of the people who lived at Bablake House. "She is very hands on for a home manager. She knows her residents so you can talk to her and she knows what is going on. She is very supportive of us and our team. We have a good working relationship."

Staff also felt well supported by the deputy manager. "She does help us and support us and she is always smiling. If we do get stuck, we ask [registered manager] or [deputy manager] for help. If we have any questions, we ask them and they are there straightaway."

An external healthcare professional felt there had been improvements since the deputy manager had taken up their role. "I have seen a good improvement with [deputy manager] coming in. She seems to be making the right changes and implementing the right systems." Another said, "[Deputy manager's] input has changed things a good deal."

Staff told us they were beginning to work better as a team to ensure positive outcomes for people. Comments included, "We do work as a team and we just help each other out." "There a lot of new staff. A lot of the old staff have gone. That is good because they wanted to run the home their way and it wasn't the right way." "It is improving in that we work as a team now and it is not just individuals doing their own thing." A member of domestic staff explained, "The carers do help us and we help them. The domestic and laundry will also help one another."

Visitors spoke positively about the home, with comments that included, "I like it here, they are well looked after", "The manager is a good lady, she has a good sense of humour," and "There are swarms of staff."

Staff were invited to meetings where they were informed of any changes and reminded of the provider's policy and procedures. For example, at the meeting in April, staff had been reminded of the infection control procedures and to encourage people to drink if they saw their cups full or half full. They also discussed the importance of maintaining confidentiality.

The provider invited people's feedback at meetings and through questionnaires. We looked at the analysis of questionnaire responses that had been completed in April 2018. We saw that where issues had been raised, action had been taken. For example, whilst most people said they were happy with the cleanliness and temperature of their bedroom, two people had said the temperature was not right. A plumber had been called out to check the radiators which were now working more efficiently.

Relatives could also provide feedback through the 'Gateway'. This was a system where relatives can access their family member's care records, with their consent, and see the care and support they had received. Whilst all relatives had been offered this facility, only five or six people had chosen to access it. The registered manager was keen to encourage others to start using it because, "It is a good communication tool to get feedback and share information."

People were listened to. The registered manager told us, "In response to a piece of dementia research with regards to sun-downing (late afternoon/early evening) the service tried having the main meal in the evening. We found this did not make a great deal of difference and, after a residents meeting, we reverted back to the main meal in the middle of day. We found staff were more able to spend quality time with people during their 'sun-downing' experience rather than trying to keep everyone at the table to eat their big meal."

The provider recorded accidents and incidents and these were logged centrally on the record system so they could be analysed by the provider to identify any trends or patterns. However, we found accidents and falls had not always been recorded in line with the providers policy. Following the inspection visit the registered manager confirmed a memo had been sent to all staff to remind where to record a fall and an accident.

The provider had introduced an employee of the month scheme to recognise those staff who had demonstrated commitment to their role and the home. The most recent winner had been nominated for being "always very helpful", "patience, listening" and, "polite and helpful".

The registered manager had also introduced a Bablake House newsletter, the first issue being in May 2018. We saw the newsletter was used to introduce people and relatives to new staff in the home and any changes within the home; training completed by staff, and planned activities. It also urged people to make suggestions and share ideas about any improvements that could be implemented within the home.

We spoke with the registered manager about dementia care and their plans for development of the home. They told us their focus was currently, "To improve everyone's well-being. By having a dementia trained workforce I hope to be able to achieve this. Now (deputy manager) is on board I can provide individualised training for staff." They continued to tell us, "We are concentrating on the environment to make it more dementia friendly. By developing another lounge area people will be able to choose to spend time in different areas instead of being all together." We suggested the registered manager consider more signage for people's bedrooms to assist the independence of people living with dementia.

Since our last inspection the deputy manager's office had been reorganised so it now opened off the main lounge. This meant they were easily accessible and more aware of what was going on in the home and the demands on staff time. Carpets in some areas of the home had been replaced with easy to clean flooring, which also made it easier for staff to move people in wheelchairs.

The registered manager walked around the home every morning to greet people, speak to staff on duty, and asses the environment. The provider visited the home regularly and the registered manager told us the provider was very supportive of the changes they wanted to make.

The provider and management team conducted regular audits of the quality of the service to make sure people received safe effective care. They also maintained a regular schedule of health and safety checks of the premises and equipment.