Bablake House Limited

Bablake House

Inspection report

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Tel: 01676523966

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Bablake House is registered to provide accommodation and personal care for up to 45 older people, including people living with dementia. The home also provides placements for up to ten people on a short term basis for re-enablement. There were 41 people living at the home on the day of our inspection visit.

At the last inspection of the service in January 2016 we rated the service as Good. Since the last inspection the provider had changed their provider name to Bablake House Limited. This meant the service was required to be re-inspected and rated. We inspected Bablake House on 6 April 2017. The inspection was unannounced.

There was a registered manager in post at the service. 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 systems and processes to protect people from risk of harm. Staff understood their responsibilities for keeping people safe and for reporting concerns about abuse or poor practice within the home. Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks. Staff's suitability for their role was checked before they started working at the home. There was a safe procedure for managing people's medicines.

The registered manager made sure there were enough staff to keep people safe. However, people and staff told us there were not always enough staff to respond quickly to people's requests for support because they were so busy. During our visit we saw there were periods of time where no staff were available in the lounge areas where most people spent their day.

Staff received the training and support they needed to meet people's needs effectively. All staff, whatever their position, had been trained to understand dementia so they could interact effectively with people living in the home.

People told us staff were friendly and caring. During our visit people were treated as individuals and were encouraged to make choices about their care. Staff protected people's privacy and dignity when providing personal care. However, how staff referred to people who required assistance to eat, did not uphold their dignity.

The registered manager understood their responsibilities in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Where people had their liberty restricted in their best interests, applications had been submitted to, or authorised by the Supervisory Body. Staff understood how to support people to make decisions about their daily lives.

There were processes to ensure people's nutritional needs were met and people had enough to eat and drink during the day. People's health needs were monitored and people were referred to healthcare services when a need was identified.

The provider used a computerised care planning system that provided up to date information about people's care needs to staff. Staff had a handover about any changes in people's care when they came on shift and received a written handover about each person on their handsets. People's care records contained individualised information about how people liked to receive their care. Most staff had a good understanding of people's needs and preferences. However, not all staff had read the handover or care plans on their handsets so were unable to tell us about people's current needs.

People told us they were satisfied with the care they received. People told us there was occasional entertainment and activities but most people said there was not much to do during the day to keep them occupied or stimulated.

Visitors were welcomed and relatives and friends could visit at any time. People and relatives told us they could express their views and opinions about the home and knew how to raise any concerns with the management team.

People who lived at the home, relatives and staff said the home was well managed. There were systems in place to monitor the quality of the service through feedback from people and a programme of checks and audits.

The registered manager and senior staff regularly checked the environment to ensure it remained safe, but they had not identified some areas of concern we found when we walked around the home. Not all notifications required to be sent to us had not been completed. It is important for providers to tell us about certain incidents in the home so we can monitor these to make sure people remain safe and well.

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 knew what action to take if they had any concerns about people's safety or wellbeing. Staff understood how to manage identified risks to people's care and there were enough staff to keep people safe. The provider had safe procedures for recruitment of staff and managing and administering medicines.

Is the service effective?

Good

The service was Effective.

Staff received an induction into the service and completed regular training to meet the needs of the people who lived at Bablake House. Where people lacked capacity, the registered manager understood the principles of the Mental Capacity Act 2005 so people's rights were protected. People received enough to eat and drink and health needs were monitored to maintain people's health and wellbeing.

Is the service caring?

Good

The service was Caring.

There was a regular team of staff who people were familiar with. 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?

Requires Improvement

The service was not consistently Responsive.

People were satisfied with their care and knew how to raise complaints if they needed to. Most staff knew people well and understood their needs and preferences. Care staff were provided with a summary of people's care plans and received a written and verbal handover to keep them up to date with people's care needs. People and staff said there were not enough

staff at all times to respond to their requests and needs. Staff supported people to participate in some activities but people said there was not much to do during the day to keep them occupied or stimulated.

Is the service well-led?

Requires Improvement

The service was not consistently Well-led.

People and staff were mainly positive about the home and the leadership demonstrated by the registered manager. Staff felt supported to carry out their roles and said the registered manager and senior staff were available and approachable. Not all the notifications required to be sent to CQC had been submitted. The quality of service people received was regularly monitored through a series of audits and checks but some environmental checks were not always robust. The registered manager had identified areas for improvement in the service, but had not had the time to put these into practice.

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 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 6 April 2017 and was unannounced. The inspection was undertaken by two inspectors, a specialist advisor and an expert by experience. The specialist advisor was an experienced nurse who specialised in dementia care. The expert by experience was a person who had personal experience of caring for someone who had similar care needs.

Before our visit we asked the provider to complete a Provider Information Return (PIR). The PIR 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. The registered manager was unable to access the information in the PIR so this was not submitted. However, during our inspection visit, we gave the registered manager the opportunity to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. We looked at information received from relatives, 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.

During our inspection visit we spoke with eight people who lived at the home, four relatives and a visitor. We spoke with the registered manager, two senior care staff, four care staff, the chef and two non-care staff. We also spoke with a healthcare professional who visited the home while we were there.

We observed people's care and support during the day. Some people at Bablake House were unable to tell us, in detail, about how they were cared for and supported because they were living with dementia. To help us understand people's experience of the service we used the Short Observational Framework for Inspection

(SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We walked around the home to view the environment. We reviewed five people's care records to see how their support was planned and delivered. We checked whether staff were recruited safely and trained to deliver care and support appropriate to each person's needs. We looked at other records related to people's care including the service's quality assurance audits, records of complaints and incident and accidents at the home.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at Bablake House. One person told us, "I feel safe here." Another said, "The staff are excellent, I have no complaints about anything. The home is spotlessly clean and I have plenty to eat and drink." Due to some people living with dementia it was difficult to ask them specific questions about feeling safe. However, the family members we spoke with had no concerns about people's safety.

Staff we spoke with told us people were safe. One staff member said this was because, "We know the residents very well, and would be able to tell if they were upset or unhappy. I have no concerns about people being safe here." We saw people were relaxed in staff's company and people's behaviour and response to staff's approach demonstrated they trusted staff.

People were safe because they were protected from the risks of abuse. Staff knew and understood their responsibilities to keep people safe and protect them from harm. All staff, including non-care staff told us they would not hesitate to report concerns. Staff understood what constituted abuse and what to do if they suspected someone was at risk. Staff told us this included changes in people's behaviour, for example if people became withdrawn, anxious, or if they acted out of character for no reason. One staff member told us, "I would tell the manager straight away, you can't have that." Staff we spoke with said if they saw or suspected any abuse, they would "pick up the phone". One staff member said, "I would go straight to the seniors and if they didn't deal with it, I would go to the manager. If they didn't do anything, I would take it to the directors." Another said they would, "Tell you guys (CQC)."

We asked staff why they should report abuse. One said, "Because it was the right and safest thing to do." Another staff member responded, "You want to treat people how you would expect to be treated". Staff said if senior staff or management were involved in the safeguarding incident, they would escalate their concerns to the local authority or us.

Staff said they would have no hesitation raising any concerns they had about poor practice within the home. One staff member told us, "I know about whistle blowing and would have no problem reporting concerns." They went on to tell us they had raised concerns in the past that had been looked into and resolved by the registered manager. They said they would do so again if they had any concerns as, "We are here to support the residents first and foremost."

The registered manager understood their responsibility to report safeguarding concerns, and had referred concerns to the local safeguarding team and submitted notifications to us as required. However, we found one recent incident that had been managed within the home that should have been reported to safeguarding and to us. The registered manager assured us they would make the referral to the local safeguarding team and notify us.

Risks were assessed for people prior to admission to the home so the provider was assured they could meet people's care and support needs. Staff we spoke with understood risks associated to people's care and

knew how to manage those risks safely. Staff told us they could immediately access people's risk assessments with information about how to support people, on their IPOD. Each staff member was allocated an IPOD, an electronic hand held device which they used to access people's care records.

We looked at five people's care plans and found the level of detail about risks varied. In three care plans there was good information for staff about people's risks. In one plan the information was not detailed, for example the person had been assessed as being at high risk of falls, yet there was insufficient information to inform staff how to limit the risk of the person falling. A senior staff member said this was because the person was at the home on a short stay basis, and for these people there was only limited information in care records. We discussed this with the registered manager who agreed additional details would benefit those living at the home for short periods of time, and that these care plans would be reviewed. This additional information would help to ensure staff were able to provide consistent care and manage known risks.

Staff were aware which people were at risk of falling due to poor mobility and their dementia, and there were procedures to reduce the risk of falls to people. One staff member said, "You can't always stop people falling but if you know they are at risk you can to try and prevent them." Where people had been identified at risk of falls sensor mats had been provided in bedrooms to alert staff when people were out of bed.

Staff had a good understanding of people's mobility skills and who required equipment to help them move. People had mobility care plans and risk assessments that provided instructions for staff if the person required assistance moving around. We observed staff helping people who walked with the use of a walking frame. They walked at the person's pace, ensured they were not rushed, and reminded people to use both hands on the walking frame for safety. We also observed staff on two occasions using a hoist to move people. People were transferred safely and staff were competent and confident using the equipment.

People who required assistance to move around had plans completed to reduce the risk of skin damage. Staff understood how to reduce the risks of skin damage to people. We were told if staff noticed any changes they reported this to the seniors so they could contact the district nurse or GP. Staff told us, "Some [people at risk] have pressure relieving mattresses on their beds and we try and encourage people sitting in armchairs to use pressure cushions." We saw the correct equipment was in place to reduce the risks of skin damage such as pressure relieving equipment and mobility aids to safely transfer people.

Accidents and incidents in the home were recorded. The records were checked and monitored by the registered manager to identify any trends or patterns. No trends had been identified.

We had mixed views from staff regarding safe staffing levels. Most of the staff we spoke with thought there was enough staff available to keep people safe, but said they would like more staff. One staff member said, "Yes there is enough staff to keep people safe, but we could do with more as it is really busy at times." Another said, "I would say, yes there is enough staff on shifts to keep people safe, as we also have the kitchen staff and domestics, but we could do with more at times." We asked care staff why they needed more staff. They told us that most shifts were extremely busy and on some occasions people had to wait for personal care or support.

Our observations supported what staff had told us. For example, when lunch was over, staff supported people who used wheelchairs or mobility aids away from the table. Some people were left in passageways whilst others were helped into armchairs. Staff were busy assisting people to the toilet and we observed there was no staff presence for almost 20 minutes in the large lounge where 15 people were sitting.

The registered manager told us they were confident there was enough staff as they used agency staff, on a regular basis, to cover staff vacancies. A senior care staff who planned the staff rotas told us there was enough staff on duty each shift. They said, "We always have six staff on duty and a senior and we use a dependency tool." We were told there was usually three staff on duty during the night, if this reduced to two due to absence, a senior staff member 'slept in'. However, they explained in March 2017 there were occasions staffing levels fell short of expected levels due to unplanned absences. The registered manager told us when needed they had worked on the floor to cover the shift. We looked at the staff rotas for the past three weeks; these confirmed what we had been told by the registered manager and senior staff member.

We saw people's care plans included individual dependency assessments which determined whether they were low, medium or high dependency. However, we found this was not effective because it did not determine how many staff were needed to support people safely. The electronic care system did equate people's care into minutes per day, but this was not accurate. The registered manager agreed to review everyone's assessed needs to make sure staffing levels remained effective to support people safely. On the day of our inspection there were enough staff available to keep people safe.

The provider had safe recruitment processes for employing staff that ensured risks to people's safety were minimised. We checked two staff recruitment files. Records showed the provider obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS provides information about a person's criminal record and whether they are barred from working with people who use services. Staff told us they had to wait for checks and references to come through before they started working with people. These checks ensured the provider could be confident staff were of suitable character to support people. When using agency staff the provider obtained confirmation from the agency that the staff member had been properly checked to provide care to people.

We checked to see whether medicines were managed safely. Medicines were stored safely and securely and kept in accordance with manufacturer's recommendations to ensure they remained effective.

We observed a senior staff member administer medicines to people. They understood the provider's medication policy and procedure and were confident giving medicines. They took their time to speak with people whilst administering their medicines, offered people drinks and explained what they wanted them to do. For example, "Here are your tablets can you take them for me, there are two tablets."

Medicine administration records had been signed by staff to confirm medicines had been given as prescribed or a reason had been recorded why they had not been given. Where people were prescribed medicines "when required" for pain relief, there were protocols (plans) in place to ensure staff gave them safely and consistently. The registered manager and senior care staff were responsible for administering medicines; they had completed training and were assessed as competent to give medicines safely.

The provider had effective systems that kept people safe in an emergency. These included regular fire alarm testing and fire equipment checks. Each person had a personal evacuation plan that provided the emergency services with important information about their mobility and any equipment needed to evacuate them safely.

Staff did not always follow safe infection control procedures. During the meal at lunchtime we observed staff did not always follow good food handling practice. Throughout the first course none of the staff were wearing aprons or gloves, and two staff picked food up with bare hands instead of using utensils. Staff did wear aprons and gloves and use utensils after the first course was served.

There were procedures to ensure the premises and equipment in the home remained safe. The provider employed a maintenance person who carried out routine checks around the building and carried out repairs. During our visit an external contractor visited to check the slings used with the hoist were in good condition and safe to use. Since our last inspection, the provider had secured the garden area with high wooden fencing so people could use the garden independently and safely if they were able to.

Good

Is the service effective?

Our findings

People and their relatives said they (or their family member) received effective care and support. One person told us, "I think that I am well looked after here." A relative told us, "[Name] had a stroke last year and was in another home for respite and they prefer it here." Another said, "[Name] has been here seven to eight months and the change in them has been 100% for the better, they are talking and making friends."

Staff told us they had the right skills, training and experience to carry out their role effectively. Newly recruited staff said they completed an induction which involved working alongside experienced staff members before they provided care on their own. The registered manager told us the induction programme for new staff was based on the Care Certificate. The Care Certificate sets the standard for the fundamental skills, knowledge, and behaviours expected from staff working in a care environment. One recently employed staff member said, "I haven't had my full training yet, but I have had some training to help people move." They told us they had been shown how to support people safely and effectively, when using a stand hoist, but never did this without supervision from an experienced staff member. The registered manager told us, as this new member of staff had not completed all their training, they did not work unsupervised.

Staff said they received regular training to refresh their knowledge and keep their skills up to date. We asked staff about their training, they said they had mandatory training yearly, which comprised face-to-face and online training. All staff said they completed training to meet the needs of people living at the home. This included moving and handling training, safeguarding, and dementia awareness. Staff were also encouraged to complete a qualification in social care. Training records showed that staff training was updated regularly and that all staff completed dementia training including non-care staff so they could interact effectively with people.

During our visit we saw staff put their training into practice by, using equipment to move people safely, communicating and interacting with people living with dementia effectively and safely administering medicines. Staff told us their knowledge and learning was monitored through supervision meetings with the registered manager or senior staff during which they discussed their personal development and training requirements.

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. Where people lack mental capacity to take particular decisions, any decisions made must be in their best interests and in the least restrictive way possible. 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 registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They explained, "If I had any concerns, I would arrange for a capacity assessment and best interest meeting." Where people did not have

capacity, decisions were made in their best interests in consultation with family and others involved in the person's care.

Most staff understood the principles of the Act and assumed people had capacity to make everyday decisions. Staff told us they checked with people first to ensure they needed assistance, rather than just assume. One staff member told us, "If residents have capacity then they should be allowed to choose what they want to do so long as it doesn't put them at risk, and that staff should always ask them first." Staff recognised the importance of respecting people's right to make their own decisions. Staff told us seeking consent from everybody was an important part of their everyday practice. We saw examples during our inspection visit, where staff offered people choices, such as, where to sit, what to do or what they wanted to drink.

For people who lacked capacity to make certain decisions, care plan records did not always record what specific decisions they needed help or support with. In one care plan it recorded 'I can't understand my decisions,' but no records supported how staff would make any best interests decisions or whether anyone else, such as a family member, advocate, or GP had been involved. One staff member said if they were unsure, "I ask the family." The registered manager said they would ensure where people lacked capacity to make decisions; best interest decisions were recorded and staff knew what actions to take. Where relatives made decisions on people's behalf their right to do this was recorded. For example where they had Lasting Power of Attorney (LPA) to make decisions in regard to financial or health and welfare matters. We advised the registered manager, where relatives had authorisation to make decisions on their family member's behalf a copy of the LPA should be obtained to confirm this.

Some people at Bablake House were living with dementia and had restrictions on how they lived their lives. Some people were under constant supervision and were unsafe to leave the home on their own. The front door was coded to keep people safe and the rear door to the garden was alarmed to alert staff when people opened the door. Applications for DoLS for people who lived permanently in the home had been authorised and documents to confirm this were available on people's care files.

Senior staff had a good understanding of MCA and DoLS, although some care staff had limited knowledge of DoLS and what this meant. When we asked one staff member about DoLS they said, "I haven't heard of that one." After we explained, they told us about people who were unsafe to leave the home on their own.

We asked people and relatives for their views on the range and choice of meals provided. People told us they were involved in choosing their food options. A relative told us their family member was not too keen on some of the food, "Our relative complains about the food and asks us to bring in sweets and chocolate, they have gone off food and have lost weight. They ask us to bring in sandwiches with real butter as that is what they are used to." Other people were quite satisfied with the food available. Comments from people included, "I'm quite happy with meals, I would like steak but realise that is not going to be on the menu. I drink a lot of water rather than tea or coffee and usually have water to hand." Another said, "Food is good but not like home. We have a good selection of sandwiches. Usual food is like meat and two vegetables with gravy. We get very good meat here, you don't need a sharp knife to cut it."

The registered manager told us that they had changed mealtimes recently and had moved the main meal to the late afternoon and served a snack meal at lunchtime. They told us this had been implemented in another of the provider's homes and had resulted in people being more alert in the afternoon. People had been consulted about changing the meal times, which they had agreed to. The registered manager was monitoring the change of mealtimes to see if it was effective.

We spoke with the chef who said there were two main options of meal available and other options if people preferred. The chef told us they gave meals simple names, rather than refer to "Fancy names they won't understand." Menus were weekly and seasonally planned and the chef said they, "Made sure all meals were nutritionally balanced." The chef knew who needed special diets such as softened, pureed or vegetarian although at the time of our visit, everyone had a normal diet.

We observed the lunchtime meal in two dining areas. Most people sat in the main dining area for their meal. People who required assistance to eat sat in a smaller dining area supported by one staff member. Some people chose to eat their lunch in their rooms. There were four people in the small dining area, two who required prompting and occasional support to eat their meals, two who required full assistance to eat. People who were able to eat independently were supported to do so. One person gave a member of staff a sachet of soup which they prepared for them. People were served a snack lunch of cheese puffs, crisps and sausage rolls, followed by chicken/ham/salmon or cheese and coleslaw sandwiches, and lemon or chocolate cake. Some people were offered chicken soup. There was a choice of orange or blackcurrant fruit squash to drink. One person asked for a cup of tea instead of the squash that was being offered and this was provided quickly. Some people in the main dining area were offered a sherry with their meal; we were told this was to celebrate a birthday. People were supported to have enough to eat and drink, had a choice of meals and ate where they wanted to.

Records showed people's health and welfare was monitored and referrals made to health professionals when needed. People had assessments of their nutritional needs completed and where people were at risk of dehydration or malnutrition their food and drink intake was monitored to ensure they received sufficient. People were weighed regularly, if their weight fluctuated this was monitored more frequently. People received regular visits from their GP or the district nurse to monitor health conditions. Care records contained a hospital transfer record, which was a summary of people's physical and emotional needs should they need to be admitted to hospital. This would support hospital staff to understand peoples existing health conditions, their mobility and capacity to make decisions.

Some people living at the home were there on a short term basis. This was to assist them to come out of hospital for a period of assessment and re-enablement before returning home or moving to alternative accommodation. During their short stay people received regular visits from physiotherapists and occupational therapists to support their rehabilitation. We spoke with a physiotherapist during our visit, they spoke positively about the support people received from the staff team and said staff always followed instructions and were available to speak with. They told us the management team were knowledgeable about people there for assessment, and the re-enablement placements were working well.

Good

Is the service caring?

Our findings

People and relatives spoke positively about the staff, and the care they provided. Their comments included, "It is a nice home and the staff try really hard." Another said, "I think staff are good," and, "I think that the staff are very good and caring to my relative."

One person told us, "We do a lot of things like celebrating people's birthdays." It was a person's birthday on the day we visited, staff were aware of this and at lunchtime the dining table where the person sat had been decorated to celebrate this.

During the day we observed interactions between staff and people who lived in the home. Staff were observed to be caring with people. For example, during lunch one person in the small dining room said they were cold. A staff member fetched a blanket and gently wrapped it around the person asking, "Is that better." The person replied, "Oh, yes that's lovely."

Staff knew people's preferred names and spoke to people in a positive way. Staff had developed relationships with people and shared a laugh and a joke. One staff member told us, "I love working here." Another told us that she loved her job because, "It feels like home and the residents feel it's their home."

Staff respected people's right to privacy, especially when personal care was provided. Staff recognised how sensitive this could be for some people and always gave people a choice of what help they needed or what they wanted to do themselves. Staff told us how they supported people's privacy, comments included, "I will ask them what they want me to do and if it's alright with them, as some people like to wash certain areas themselves. I make sure they are always covered up." During our observations staff spoke discreetly to people when they asked about personal care and escorted people to bathrooms or their bedrooms to deliver this in private.

We observed staff transfer people using a hoist. They reassured the person using the hoist during the transfer and moved the person from the lounge to the toilet in a dignified manner.

People were supported to do things for themselves where possible. Staff told us how they promoted people's independence. Comments included, "We always try to give choices and support them to do what they want to do." We saw people were encouraged to make choices about their care. This included how people wanted to spend their day, what clothes to wear, where they would like to sit, and their choice of food. We saw some people preferred to spend time in their bedrooms rather than sitting in the communal lounge. On the day of our visit people looked clean and groomed.

We saw staff knew what to do to relieve people's distress. During our visit one person became agitated in the afternoon. Staff knew how to use distraction techniques to divert the person's attention and calm their anxieties.

Staff supported people to maintain relationships with family and those closest to them. All the people and

relatives we spoke with said that there were no restrictions on their relatives, friends or people from church visiting them at any time. Comments included, "Relatives can come and see me whenever they want to and I get taken out for lunch or dinner which is nice," and, "The home is handy for my wife who lives close by and she comes in when she wants to."

People told us they were treated with respect, one person told us, "Staff always knock on the door before they come in so they do respect my privacy." However, two people told us the door to their en-suite toilets were sometimes left open which meant they sat facing this during the day which they did not like. They said, "The door to the toilet is always left open even though I don't use that room as I am totally incontinent," and, "My chair faces the toilet and usually the door is shut but they haven't shut it at the moment."

Whilst people's privacy and dignity was respected, we heard two staff refer to people who required assistance to eat, using terminology that was unacceptable and not respectful to those needing support. We discussed this with the registered manager, who said they would tell staff to stop using this undignified term immediately.

Some people's names and photographs were displayed on the wall outside their rooms, which encouraged a sense of personal ownership. However this had not yet been completed for everyone.

People's personal details and records were held electronically, and staff accessed these on their handheld IPOD. People's information was held securely as each staff member required a passcode to access the information. However, if a device was left unattended the device did not automatically lock. We highlighted this to a senior staff member who immediately pass-coded each device so this would 'lock out' and prevent unauthorised people from accessing personal information. During our inspection we observed individual IPODs took three minutes to lock out. This seemed a long time and could leave the system vulnerable if the device was picked up if accidentally left unsupervised. We advised the registered manager to review this to ensure people's personal information remained secure and confidential.

Requires Improvement

Is the service responsive?

Our findings

We found the care and support people received was not always responsive to people's needs and requests. People told us, "Two or three of the staff are excellent. The care has got better, but I have to put up with the care I am getting. I have been asking staff to get my finger nails cut for weeks but they still have not been cut." Another said, "I have been here seven weeks and only had one shower, I would prefer a bath but not been offered one." A relative told us, "[Name] always wakes early and the staff knew this so would bring them a cup of tea. But that has stopped now and we are not sure why as our relative appreciated that." In the afternoon we saw a person calling out for help. As there was no staff in the lounge we went to find a member of staff to let them know the person was distressed. We told a senior staff member who said the person was always crying out and there was nothing wrong with them. They did not go to the person to see if they could assist them.

People told us they expected to wait if they asked staff for anything. Comments included, "They definitely need more staff, lucky to get two staff on. There are a lot of us over two floors, you can ask for something and have to ask for it again a little while later." Another said, "I am a wheelchair user and it would be better if they had more staff. I have a container of fluid but I cannot pour it into the glass, and it can be quite a wait until someone comes as there are a lot of us to look after. There isn't a high turnover of staff which helps as they know my needs."

People told us about their preferences and choices and how they would like to spend their time. One person told us, "I used to like gardening and so I enjoy the view from my bedroom window as it overlooks the garden." Another said, "I am quite happy to stay in my room as I have a really comfortable reclining chair and it doesn't bother me being by myself."

People told us they would like more to do in the day. Comments included, "I am 95 and thought that there would be more stimulation and activities here. I am very disappointed. Luckily I have found two other residents who I can have a conversation with." Another told us, "A friend comes in and plays draughts most days. No other activities are set up for me." Relatives also said there was not a lot for people to do, one told us that their family member was finding it hard to cope as there were so few people to talk to and no activities to keep them stimulated. Another relative told us, "[Name] would love to go out and about but there is not enough staff to do that."

During our inspection visit, one staff member was singing and dancing with people who wanted to join in. However, other staff told us they had limited time to support people with hobbies and interests. One staff member said, "We are running around doing things." Staff felt there was enough staff to ensure 'tasks' were completed and people were safe, but there was limited time to sit and chat with people. There was a list of planned activities such as a day trip and external entertainment; however for the 'everyday' there was not much to do.

The environment supported people to sit with others and watch television or listen to music, whilst other areas of the home were quieter if people wanted to spend time on their own. Books were available for

people to read if they wanted. People who preferred time to themselves were supported to do the things they wanted, such as spending time in their room, walking around the home or enjoying the garden.

We found the service could be more individualised and person centred. For example people indicated they did not choose the times they got up or went to bed. People told us, "I can be got up anywhere between 5.30am and 9.00am, it all depends on how the night staff have got on. The answer is definitely to get more staff." Another said, "They get me up at 7.15am and breakfast is not served until 8.00am so I'm sitting around for a while. They put me to bed about 7pm which doesn't bother me as I have a TV in my room." A staff member told us about one person, "When they wake her up early she doesn't eat, if she sleeps till about 8.30am she is fine," again indicating people did not have a choice about the times they got up. One staff member said after the evening meal, "Staff take people to bed to help night staff." They told us they had a system to 'toilet' people and told us, "doubles went first, and then singles". This was not responsive to individual needs. One staff member described the care as, "Good, but institutionalised."

We spoke to a senior staff member about person centred care. They told us that people should be treated as individuals and that the more staff know about a person's past, present and future the better equipped they were to understand them and provide for their individual needs. They gave an example of a person who sometimes liked to sleep away from their bedroom during the night. They said night staff were aware of this and accommodated the person's needs when this happened.

However, we saw occasions when people did not receive person centred care. During lunch we observed one member of staff supporting four people in the small dining room with their meal. Two people required prompting and occasional support to eat their meal and two people needed assisting to eat. The member of staff was assisting the two people who needed help to eat at the same time, which meant neither person had individual attention or support to eat their meal. They also had to leave the people they were assisting to support the other two people, who required intervention regularly during the meal time. All four people were not supported to eat their meal in a person centred way.

The lunchtime experience was not well organised or responsive to people's needs. While people were at the dining table, the cleaning staff were in the lounges wiping chairs and tables and vacuuming, which was not very relaxing for people. Staff seemed rushed and people sat at the dining tables for long periods of time before they were served their food and after they had finished eating. For example some people were bought to the tables by staff from 11.30am and lunch was not served till after 12.30pm. One person complained that they had been sitting there for more than half an hour. When the meal was finished people who required assistance to move away from the tables had to wait until staff were available to do this. In the small dining area, one person asked to leave the table at 1.35pm, they were asked to "wait a minute" by the staff member in the area who was busy with another person. They asked again several times, and after another ten minutes said, "I need help, how long is your minute, can I leave the table please I don't want to wait any longer." The person was still asking to leave the table at 1.50pm. We asked staff if they thought there was sufficient staff available. They told us, "No, mornings and lunchtimes are really busy. There is sometimes more than six staff, it runs more smoothly then." Staff told us they needed more 'eyes and ears' on the floor.

We spoke with the registered manager about staffing levels. They said the dependency tool used to assess staffing levels did not take into account the environment or people living as a group. They told us they would like to have another member of staff on each shift to enhance people's lives and to have constant staff presence in the lounges. They went on to say if there was an extra member of staff they would be able to engage people in more activities to improve their emotional wellbeing.

Staff told us they had a handover meeting at the start of their shift which updated them with people's care needs and any incidents since they were last on shift. Information from staff throughout the day was captured electronically which formed the basis of the handover information. Staff were required to read this twice during their shift, and respond to show they had read this. The senior staff member told us staff always read the handover. However we checked at 1.30pm and five staff had not signed to say they had read the morning handover, and this had not been picked up by the seniors. Staff did tell us they had read it, but forgot to record this. One staff member told us their shift had been busy and they had not had time to read it. We were told by the senior staff the person had been verbally informed how people were feeling and what to look out for.

People's care plans had recently been transferred into electronic versions, that staff accessed by hand held devices. We looked at five people's care plans, these reflected how people would like to receive their care, and included personal information, health needs, preferences, and daily living tasks. The system alerted the seniors when they were due to be routinely reviewed. Staff were able to record directly into the IPOD any tasks they had completed or checks they had made on people. The registered manager said the system worked well but was aware people's care plans were not very person centred. They said as plans were reviewed this would be improved. Staff said they liked the new care plans and that it was a good system. One staff member told us they particularly liked the handover because, "It allowed you to read exactly what was going on without having to listen to stuff which was not relevant."

We did identify that for people on short stays, plans were not always detailed. One staff member said, "I know people's names and routines, but for some the information is limited." We looked at a psychological care plan for someone recorded as being anxious, there was limited information to tell staff what they needed to know and do to reduce the person's anxieties. We discussed this with the registered manager who agreed short stay care plans needed further reviewing and updating.

We asked the registered manager if there were any people whose behaviour was a challenge due to their dementia. They told us about a person who became restless and agitated as the afternoon wore on. They said this was managed by distraction techniques and trying to keep the person occupied with walks and conversation. We saw staff put this into practice during our visit. However, there were no written guidelines for staff to follow in the persons care plan, to make sure this was managed consistently and safely. The registered manager and seniors assured us guidelines would be completed.

No one we spoke with had any complaints about the service they received. People knew who the registered manager and senior staff were and said they would feel confident discussing any issue with them. People and relatives said they were confident if they had any concerns they could approach staff or the management team who they felt would take their concerns seriously.

Staff knew how to support people if they wanted to complain. One staff member told us, "If someone wanted to complain I would ask them about their complaint and ask if they were happy to talk to me about it or if they wanted to speak to a senior. I would also let the senior or manager know the person had a concern, they would go and speak with them."

We looked at the complaints record and found one formal complaint had been received in the past 12 months. This had been recorded, investigated and responded to in line with the provider's complaints policy.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with said they (or their relative) liked living at Bablake House. One person told us, "I have a ground floor room which is lovely." A relative said, "We would recommend this home to other people."

Staff said they enjoyed working at the home. One staff member said, "I like coming here, I like the residents and to see them smiling." This staff member said they liked working as a care worker because, "I make a difference to people."

People and relatives knew who the registered manger and senior staff were and said they were visible within the home. The management team were knowledgeable about the care and support needs of all the people living at the home. We observed people had no hesitation approaching the senior staff to say hello, or request assistance. Staff were clear about the management within the home and were complimentary about the seniors who led and managed the shifts.

The home had a registered manager who understood their role and responsibilities. The ratings from the last inspection were displayed in the entrance hall and some notifications had been submitted following incidents in the home. However, we found we had not been notified of all incidents and events that had occurred in the home, this included, serious injury following a fall and notifications when authorisations had been agreed to restrict people's freedom (DoLS).

The registered manager told us they conducted a 'walk around' several times a day, and explained they used the 'walk around' to observe staff practice and to check the environment. However, during our walk around the building at the start of the inspection we identified several concerns which we discussed with the registered manager. The cable connection on the falls sensor in one room was frayed and the wires were showing. The registered manager reported this to the maintenance person for repair and the mat in the room was changed. Domestic staff used trolleys to transport cleaning equipment and substances around the home. We saw trolleys left unattended for periods of time with substances that were hazardous and should be locked away when unattended. The registered manager said they would purchase hand held baskets for housekeepers to use and confirmed these had been ordered during the inspection. Some people at high risk of developing skin damage had pressure relieving mattresses on their beds. We observed that the settings on pressure relieving mattresses were not regulated dependent on people's weights as guidelines recommend. The senior member of staff who accompanied our walk around the home was unaware of these guidelines. However the registered manager was, and said they would contact health professionals so they could record the right settings for people and adjust the settings accordingly. Following the inspection the registered manager contacted the external mattress supplier and sought guidance for staff to follow.

Although the registered manager took immediate action to rectify the concerns we raised, these issues had not been identified by the management team prior to our visit.

Staff had regular supervision and appraisals to review their practice and discuss any personal development.

Staff also had staff meetings where they could share their views and opinions about the service. However, the registered manager told us these did not happen as often as they would like. They told us, "We do have smaller informal meetings but these are not recorded."

The registered manager told us they held "residents meetings" three to four times a year. The next meeting was planned for April 2017. At the last meeting in December 2016 the minutes showed changes to the lunchtime meal had been discussed and agreed with people.

We asked the registered manager how they kept their dementia care skills and knowledge up to date. They told us they had recently completed a diploma in dementia care and were able to update their dementia skills and knowledge through the company that provided the training. They said the company had also provided a memory stick with lots of dementia information on it.

We asked how they shared their learning from the training with staff and how this had benefited people living in the home. The registered manager told us they had lots of ideas from the dementia training but at present had not introduced anything new due to lack of time. They told us they would like to "Take Bablake House forward to be more dementia friendly. I would like more staff and be able to provide more dementia awareness with staff. I hope to improve the environment and be able to group people in smaller areas. When the new lounge is built we should be able to do this."

We asked the registered manager what the challenges were in implementing changes. They said "I feel as if we are standing still. I need time to spend with staff to take this forward. I have not been able to implement everything I learned on my course due to lack of time and staffing. The day to day running of the home takes priority. I would like to be able to plan development time with the staff group."

One relative described the home as dark, old fashioned and dated. We asked the registered manager if they thought the environment was suitable for people living with dementia. They said they had lots of ideas how to change what was available for people such as different colour schemes in the hallways and changing bedroom doors to look like 'front doors' to give people ownership. They said the premises and equipment in the home had improved and continued to get better. They explained the provider's plans to develop and improve the environment for people. We saw work was being done to modernise the home with some rooms having recently been decorated.

The registered manager had implemented a survey for people to share their views about the service and a feedback questionnaire for people to complete when they left the home. Completed surveys received in March 2017 had not been collated at the time of our inspection but comments on surveys we viewed showed people were positive about the care provided. Comments included, "Brilliant wouldn't want to leave," and "I wouldn't change you for the world." Another person had written, "I have only been here a few weeks but have been made to feel welcome and have settled well."

The provider and management team used a range of quality checks to make sure the service was meeting people's needs. These included checks to ensure care plans were reviewed and kept up-to-date. Medication records were audited to make sure people had received their prescribed medicines. Accidents and incidents were recorded and monitored for trends or patterns. No trends had been identified. The registered manager told us the provider visited the home regularly and carried out checks as part of the quality assurance procedures. They said the provider had started to record these visits to provide an audit trail of actions taken.

The registered manager worked in partnership with other professionals to ensure people received

appropriate care and support. This included social workers, G.Ps, physiotherapists, the district nurse team and the local authority contracts team