Gospel Standard Bethesda Fund

Studley Bethesda Home

Inspection report

Church Road
Derry Hill
Calne
Wiltshire
SN11 9NN

Tel: 01249816666

Date of inspection visit:
18 January 2018

Date of publication:
14 March 2018

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?	Requires Improvement

Summary of findings

Overall summary

Studley Bethesda Home situated in Calne, is one of three homes run by the Gospel Standard Bethesda Fund who provide personal care and accommodation for people over the age of sixty five, who are members of Gospel Standard Strict and Particular Baptist Churches; or who regularly attend Gospel Standard Strict Baptist chapels. Studley Bethesda Home provides care for up to thirteen people. At the time of our inspection there were eleven people living there, ten people being permanent residents and one person having respite services, in one adapted building.

Studley Bethesda Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Studley Bethesda Home was last inspected in October 2015 and was rated as Good overall. This inspection was unannounced and took place on 18th January 2018 and we found that standards had been maintained.

A registered manager was not in place at the time of our inspection. 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. An interim manager was in post and worked alongside the registered manager throughout December 2017, to complete a full handover. The interim manager will remain in post until a new registered manager is appointed.

People told us they felt safe. Staff knew, and understood their responsibilities for safeguarding people against potential risk, or harm and were able to tell us how they would report any concerns. Staff received individual support meetings and training to support them in their role and staffing levels were appropriate to meet people's needs. Risk assessments were in place which identified specific risks for individuals and detailed the support required.

Medicines were administered, recorded, stored and disposed of safely. People were encouraged to self-administer their own medications and were supported by staff in a safe manner. Protocols were in place for PRN (as required) medications, instructing staff on how and when to administer them.

People had access to food and drink throughout the day and were encouraged to make their own hot and cold drinks using the resident's kitchen. People had been consulted about their meal preferences and were offered choices. People were supported to follow specific diets necessary to maintain their health and well-being.

People were supported to make their own decisions and staff had a sound knowledge of the Mental Capacity Act (2005) and how to apply this to the support they provided. Care and support plans were

personalised and reviewed regularly.

There were auditing processes in place to monitor the quality of the care and services delivered. People and relatives were encouraged to give their views and ideas for change. People and their relatives were complimentary about the staff and the care they received.

Providers are required, by law, to display their CQC rating to inform the public on how they are performing. The latest CQC rating was displayed in the service and these details were also on the provider's website.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People said they felt safe living at Studley Bethesda Home and there were enough staff to meet people's needs.

People were protected from potential harm and staff knew the procedures to follow if there were any concerns.

Risk assessments were in place which detailed the support staff needed to provide to reduce the risk.

Medicines were administered safely with protocols in place for 'as required' medicines and people were supported to safely manage their own medicine administration.

The home was clean and tidy, with infection control procedures in place.

Is the service effective?

Good

The service was effective.

People were encouraged to make their own decisions and staff had a good understanding of the Mental Capacity Act (2005) and how to apply this to the care they provided.

People's dietary requirements were met and their preferences catered for.

Staff had regular training and supervision to support their role.

The home worked with health professionals to ensure people had access to healthcare.

The home was decorated and adapted to suit the needs and preference of the people living there.

Is the service caring?

Good

The service was caring.

People and relatives spoke positively about the care they received.

Staff interacted with people in a gentle and dignified manner and were respectful of people's beliefs and religious needs.

People were relaxed and comfortable in their surroundings.

Is the service responsive?

Good

The service was responsive.

Care and support plans reflected people's individual needs and gave staff clear guidance on how to provide care to meet people's needs.

People were able to practice their strict faith in the manner they preferred, having daily bible readings, religious services and residing in a calm and quiet atmosphere in the home.

There was a suggestions box and a complaints procedure for people, staff and relatives to use, people knew how to make a complaint but did not feel the need to do this.

Is the service well-led?

Requires Improvement

The service was mostly well-led.

Studley Bethesda Home did not have a registered manager in place at the time of our inspection.The interim manager had completed a full handover alongside the previous registered manager.

There was a clear ethos and good standard of care which was reflected in the management systems.

There were systems in place to gather people's views on the running of the home.

The staff team knew the people they supported well and how to provide care whilst respecting their religious faith and preferences.

Studley Bethesda Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 inspection took place on 18th January 2018 and was unannounced. The inspection team consisted of two inspectors. Before the inspection, we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to tell us about. 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.

Throughout our inspection we spent time observing care at the home. We spoke with three people and two relatives. We also spoke with the interim manager, the deputy manager, two senior care assistants, one member of the housekeeping team and the cook. We reviewed records relating to people's care and other records relating to the management of the home. These included the care records for four people, medicine administration records (MAR), three staff files, the home's policies and a selection of other records relating to the management of the home. We observed care and support in the communal lounge and dining areas during the day and spoke with people around the home.

Good

Is the service safe?

Our findings

People felt safe in the home. People were protected from potential abuse and harm. One person said, "I feel safe with the staff, the staff are very good." The home had a safeguarding policy and procedure in place and the Local Authority contact details and flowchart were on display in the office. Staff knew and understood how to identify abuse and how and when to report it. They had received the provider's mandatory training in safeguarding and the records showed when this had been completed and when a refresher course was next due. One staff member told us, "I would report it to a senior or the manager, the Wiltshire safeguarding team or the police." Another member of staff told us, "I have to look for any signs and report it to the manager or the deputy." The staff we spoke with were also aware of how and when to whistle-blow, but had not had to do this. Whistleblowing is the term used when a worker passes on information concerning wrongdoing. The wrongdoing will typically (although not necessarily) be something they have witnessed at work. There were no safeguarding or whistleblowing notifications at the time of this inspection.

People were protected from the risks of harm and a range of individual risk assessments and action plans were in place, which were reviewed monthly. For example, one person was at high risk of malnutrition and subsequent skin breakdown due to immobility. Assessments completed by the community nursing team informed the risk assessment and detailed the action to take to minimise the risk; these included regular re-positioning, checking of the air mattress and close monitoring of the person's food and fluid intake; a daily care log showed " [the person] drank 50mls of apple juice, 200mls of fortisip and 200mls of hot chocolate." A body map showed where red marks had been identified, the action taken and when the marks had healed. The cook ensured that this person had a high calorific soft diet and was aware that they preferred small regular meals.

Incidents and accidents were monitored. For example, for one person a falls record was in place to monitor the regularity of falls and detail the actions arising. Most falls were recorded as 'rolling out of bed'. A 'crash mat' and a 'low level bed' were provided to prevent injury from rolling onto the floor. Staff checked the person for injury or bruising and a hoist was used to assist the person back into bed.

The staffing levels meant that people received care and treatment when they needed it. We observed four members of staff on duty, the rotas were managed to minimise stress and tiredness. For example, there is one waking and one sleeping night staff. The sleeping staff member goes to bed at 11pm and starts again at 7am. If they were disturbed during the night then they would not complete the early shift the next day. The staffing levels were confirmed by reviewing the duty rota. A relative told us that, "The staff have been stretched as there were only two care workers on duty but during the last few weeks, staffing levels have increased." One person told us, "They now have more staff at the weekends." We were told that there was a very low turnover of staff and the home had not had to use any agency support, which was evidenced when reviewing the rota. We observed that bells were answered promptly, staff appeared to have time to spend with people chatting and people's requests were quickly accommodated.

Staff were employed safely. We looked at three staff files and all of the required safety checks were in place which included DBS, appropriate references and identity checks. The Disclosure and Barring Service (DBS)

helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. New staff were subject to an induction programme and were shadowed until competency was demonstrated. It was clear from the interview notes that the religious ethos of the home was discussed at interview so that staff could make sure they were happy with this prior to commencing employment.

The home was supporting people with the administration, storage and disposal of medicines in a safe manner. People were supported to self-administer their medicines and a risk assessment and lockable cabinet or drawer were in place for people who wished to maintain independence in this area. The medicines policy had clear procedures in place for example, protocols for creams and PRN (as required) medicines. Body maps were in place to instruct staff where specific creams were to be applied and for a person who required an alternating site for a medication patch. The use of homely remedies had specific guidance, for example, one person was at risk due to their low weight, they could only receive one paracetamol instead of two. The staff member we spoke with was also aware of GP instructions not to administer codeine with night sedation for this person. A homely remedy is another name for a non-prescription medicine that is available over the counter in community pharmacies. They can be used in a care home for the short-term management of minor, self-limiting conditions, e.g. headache, cold symptoms, and mild occasional pain. Each person had a MAR (medicine administration record) which showed that staff had administered the medicines at the correct times and dosages. The medicines trolley was locked, chained and stored in a locked room. The home used a medicines communication book which the senior staff checked. This enabled important information regarding a person's medicines to be fully communicated to staff on different shifts.

The interim manager had identified risks related to the environment. The building was very clean, tidy and well maintained. There were pots of anti-sceptic hand gels placed along the corridor and in communal areas. Staff we spoke with were knowledgeable about infection control processes including the safe use and storage of cleaning materials and the safe disposal of waste, they were observed using PPE (personal protection equipment). The kitchen had recently had an environmental health inspection and was rated at five, the highest level. There were fire exit signs in place, fire doors were closed and fire extinguishers placed in visible areas. Personal Emergency Evacuation Plans (PEEPs) were in place with arrangements to use a local building as an evacuation centre if required. Baths had thermometers and rubber slip mats in place. Instructions on how to safely use the bath lift was visible. The home employed an external Health and Safety consultant to advise on all aspects of health and safety in the workplace.

Good

Is the service effective?

Our findings

People were supported by staff who had access to training to equip them with the skills and knowledge they needed. Staff training records were clear and detailed the date training was completed and when it was next due. Training included food hygiene, health and safety, moving and handling, diet and nutrition, fire safety, infection control, medication, dementia awareness, COSHH (control of substances hazardous to health), first aid, diabetes, person centred care and MCA and DoLS (the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards). Topics were re-visited every three months by use of external courses and training provider. The home also made use of training provided through their network of support services for example, the local authority, the local hospice, Wiltshire and Swindon Care Skills Partnership and LEN (learning education network).

Records of supervision were seen. These included a three monthly check on medicines' competencies. Annual appraisals were seen. These included discussions around the homes ethos and values. Staff confirmed that they received regular supervision in one to one sessions, which looked at their skills and training requirements, as well as informally throughout the day. Staff told us they were encouraged to improve their skills and would discuss during supervision, appropriate courses such as a level four leadership course and a level three QCF(qualifications and credit framework) courses to consider.

People were complimentary about the choice of meals and the food cooked at Studley Bethesda Home. The cook told us that a cooked breakfast was available on a Wednesday and they had cooked lunches with a lighter evening meal. The cook was very aware of people likes and dislikes and this included people who requested or required specific diets due to reduced appetite, weight loss or specific dietary requirements. We heard a discussion between the cook and staff asking what a person would like. The cook stated, "Ask him if he would like some of my homemade soup." The cook confirmed that people could have what they wanted, when they wanted it. A family member told us, "The staff ensure [my relative] has a varied [specialist] diet and [my relative] is given options also. Yesterday there were two choices for tea, both of which [my relative] didn't want, so [my relative] asked for tinned tomato soup which [they] enjoy and they were happy to do this." Staff could access the kitchen in the evenings and over-night to provide snacks for the people living in the home. There was a small kitchenette for people to make their own drinks and fruit and snacks were available on the tables. At lunchtime we observed that vegetables were served to the tables in dishes so that people could help themselves. The meal served was the same as what was detailed on the menu and discreet assistance was given when one person needed their food cutting up.

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be legally authorised under the MCA. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). No-one currently living in the home was subject to a DoLS authorisation, people had capacity and therefore there was no requirement for mental capacity assessments at the time of the

inspection.

Staff however, had a sound knowledge of the Mental Capacity Act (2005) and what having capacity meant. One staff member told us "I always assume the person has capacity to make decisions." Staff told us that people were encouraged to make their own decisions and to remain independent in this area "[the person] can make [their] own decisions and choices". We observed staff enabling people to make choices and gaining consent when assisting people. For example people were asked if they would like any pain relief, which kind and how much. Staff knocked on doors and asked if they could enter. Staff asked permission when they were assisting people to stand or move their foot position. Staff confirmed that people living in the home had capacity to make their own decisions but staff would be able to explain the risks and consequences of any decisions they made. Signed consent forms were observed to be in the care and support plan.

People were supported with access to appropriate healthcare to maintain their health and well-being. A GP visited regularly and the community nursing team assisted with specialist assessments and the provision of equipment to meet specific health needs. A dentist, optician and chiropodist made regular visits and the outcomes of these check-ups were detailed in the care and support plans.

The home was clean and tidy and people were encourage to bring items of furniture and personal belongings to decorate their rooms. The home had a very peaceful and calm atmosphere which was the preference of the people living there.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received at Studley Bethesda Home. One person told us they felt, "Pretty well looked after, the staff get to know you and you get to know them." A family member told us, "Our [relative] is very well cared for, the staff are kind, caring, courteous, professional and on hand to listen to any concerns." People were treated respectfully. Staff were observed to knock on doors before entering and care and attention was provided in a timely and un-rushed manner. People's daily routines of bible readings, and church services were integral to the daily running of the home. One staff member said, "We do things the way they like it."

Staff spoke with people in a gentle and sensitive manner. We observed polite and caring interactions and staff were respectful of the wishes of people to have a quiet and peaceful atmosphere. One staff member spoke with a person and said, "Just ring me when you are ready." One person was seen being supported to slowly and carefully mobilise using their frame. One person spoke with a member of staff about her glasses which were ready to be collected from the optician and the staff member assured her that she would collect them for her that afternoon, "Oh, that would be lovely, thank you very much."

Visitors were welcomed and were able to come and go as they pleased. A family member told us, "[the staff member] was sat chatting with [my relative] in the lounge having [their] coffee break, which we thought was very caring." Most staff members had been providing care at Studley Bethesda Home for many years and the turn-over of staff was low. One staff member said, "I like it, it's very different to some of the larger homes I have worked in, you can really get to know the person."

Good

Is the service responsive?

Our findings

People chose to live at Studley Bethesda Home due to its religious ethos and people could continue to live their lives within the faith they had chosen on a daily basis. This included services being held by people who lived in the home, regular daily bible readings and visits to the chapel and church services held by the local pastor. One person said they chose to live at Studley Bethesda Home as they knew the home in Brighton where they had had respite care. Another person said they liked the chapel and the pastor.

Care and support plans showed that staff knew the person well, their preferences, their routine and the most beneficial ways in which to support them. The care and support plans were comprehensive and detailed people's past lives, their families and their interests, they also covered healthcare and physical needs as well as having a particular care plan for spiritual, emotional and intellectual well-being. These were reviewed monthly. Some care plan reviews were signed as read and agreed by the person. One staff member said, "I know the residents. They normally have a definite routine so you know when something is wrong." One person said if they get up one morning at 4am the staff would bring them a cup of tea, but they would also bring them their usual cup of tea at 6am as well. One family member said, "We are very happy about the care [our relative] receives and have no complaints."

Care and support plans detailed areas of care in which the person was more independent and how staff could support this. Several people administered their own medicines and had a small locked cupboard in their rooms to store the medicines. Staff supported them by checking and auditing. One person told us, "I look after my own medication, I have a drawer locked up and they check on it regularly." One person who self-medicated told a senior member of staff that they had taken one of their medicines a day too early. This was checked and the staff member informed the manager and rang the GP who confirmed it was safe. This was recorded in the error report book.

The home used an 'at a glance' care plan which summarised the main elements from the larger care plan. Staff had a thorough handover between shifts which highlighted people's health and well- being and any particular circumstances staff needed to be aware of. For example, one person was showing signs of becoming unwell with a possible infection. The staff were instructed to monitor the person's levels of drowsiness and breathlessness and to obtain a urine sample and contact the GP if this did not improve within a specified time limit. Another person was being monitored closely for signs of tissue breakdown, this included body maps and detailed recordings of when and how often to support this person to move positions.

People stated that they liked to reflect and read their bible and so did not want large amounts of organised activities. There were trips to Bowood House, knitting and exercise groups which were planned weekly, details of which were displayed in the reception area. One person said, "There's enough to do, it's mostly good and we get on pretty well."

All care plans contained a specific end of life care plan, detailing actions to be or not to be taken (this included DNACPR orders) which had evidence of being discussed and devised with the person. The purpose

of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly.

There was a suggestions box and one complaint had been received in February 2017 about the bath being dirty; it was investigated by the registered manager (in post at the time) in line with the complaints procedure. It was clear that the registered manager had reflected on the complaint and considered any lessons learnt. These reflections took place with the staff team. There was a very clear outcome letter sent to the complainant which included an apology. We looked at the minutes from residents meetings in 2017. There was clear evidence that people's views were taken into account and regular newsletters were created informing people of news, changes or events.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in place at the time of our inspection. An interim manager was in post and the provider was actively recruiting a new registered manager, with interviews being held at the end of January 2018. The previous registered manager had worked alongside the interim manager for one month throughout December 2017, to support them with a comprehensive handover and continuity of home management.

Providers are required, by law, to display their CQC rating to inform the public on how they are performing. The latest CQC rating was displayed in the service and these details were also on the provider's website.

There is a clear structure of line management support in place. The current interim manager stated that she received weekly support and visits from the regional manager. One relative told us, "The management of the home is good" and "recently the manager has left, the [interim manager] is very friendly and helpful." We observed staff sitting and chatting to people and the interim manager was visible within the home.

Staff said they felt supported by the management team and one staff member told us, "One night there was a storm which resulted in a power cut. The registered manager came over to the home at 4am and stayed to support the people and the staff until daylight. Call bells were working due to a back-up generator, but people were issued torches and were supported to stay in their rooms safely until full power was resumed." Staff told us that before the previous registered manager left, they carried out a full hand-over to the interim manager which included a four week induction to maintain the continuity of care for the people using the service and for line management of staff.

The interim manager told us that the ethos of the home is based on their religious beliefs and to provide a high standard of care for the people living in the home. This was supported by the homes Statement of Purpose and the staff we spoke with had a clear understanding and respect of these values.

Arrangements were in place to gain people's views. People, family members and staff were asked for ideas and a suggestions box was clearly visible in the main hall entrance. Staff meeting minutes showed where discussions had taken place and views and suggestions were gained. We looked at the minutes from residents meetings in 2017. There was clear evidence that people's views were taken into account and regular newsletters were created informing people of news, changes or events.

Quality control checks were in place and were carried out monthly which ensured the care and treatment people received was monitored. The areas covered included, staffing, medicines administering checks, infection control, health and safety and care plans. The audits were kept in a folder which the regional manager reviewed. Where any gaps were identified the regional manager would devise action plans which were then re-assessed during the next visit. Complaints and feedback were audited alongside ideas from the suggestions box and 'niggles and gripes'.