Country Care (Nafferton) Ltd

Lavender Court Residential Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Outstanding

Overall summary

This inspection took place on 26 March 2015 and was unannounced. We previously visited the service on 28 October 2013 and found that the registered provider met the regulations that we assessed.

The service is registered to provide personal care and accommodation for 18 older people who may have a memory impairment. The home is located in Nafferton, a village that is close to the town of Driffield, in the East Riding of Yorkshire. It is close to village amenities. Bedrooms are mostly single and some bedrooms have en-suite facilities.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality

Summary of findings

Commission (CQC); they had been registered since 23 April 2013. 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.

People told us that they felt safe living at the home. Staff had completed training on safeguarding adults from abuse and were able to describe to us the action they would take if they had concerns about someone's safety. They said that they were confident all staff would recognise and report any incidents or allegations of abuse.

We observed good interactions between people who lived at the home, staff and relatives on the day of the inspection. People told us that staff were caring and compassionate and went "Over and above."

People were supported to make their own decisions and when they were not able to do so, meetings were held to ensure that decisions were made in the person's best interests. If it was considered that people were being deprived of their liberty, the correct documentation was in place to confirm this had been authorised.

Medicines were administered safely by staff and the arrangements for ordering, storage and recording were robust.

We saw that there were sufficient numbers of staff on duty to meet the needs of people who lived at the home.

New staff had been employed following the home's recruitment and selection policies to ensure that only people considered suitable to work with vulnerable people had been employed. Staff received a thorough induction programme before they worked unsupervised.

People who used the service and relatives told us that staff were effective and skilled. Staff told us that they were happy with the training provided for them, and that they could request additional training if they felt they needed it.

People's nutritional needs had been assessed and people told us that they were satisfied with the meals provided by the home. People were supported appropriately by staff to eat and drink safely and their special diets were catered for. The home had received an Nutrition Mission award.

There were systems in place to seek feedback from people who lived at the home, relatives, health and social care professionals and staff. People's comments and complaints were responded to appropriately and people felt that this had led to improvements being made to the service they received.

People who lived at the home, relatives and staff told us that the home was well managed and one relative described the home as "Progressive." The quality audits undertaken by the registered manager were designed to identify any areas of concern or areas that were unsafe, and there were systems in place to ensure that lessons were learned from any issues identified, and to promote continuous improvement.

Summary of findings

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 is safe.

The arrangements in place for the management of medicines were robust and staff had received the appropriate training.

Staff displayed a good understanding of the different types of abuse and were able to explain the action they would take if they observed an incident of abuse or became aware of an abusive situation.

We found that there were sufficient numbers of staff employed to ensure that the needs of the people who lived at the home could be met. Recruitment practices were robust and ensured only those people considered suitable to work with vulnerable people were employed.

The premises were being maintained in a way that ensured the safety of people who lived, worked or visited the home.

Is the service effective?

Good

The service is effective.

People were supported to make decisions about their care and best interest meetings were arranged when people needed support with decision making. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff told us that they completed training that equipped them with the skills they needed to carry out their role and this was supported by the records we saw and the other people we spoke with.

People's nutritional needs were assessed and met, and people's special diets were catered for. We saw that staff provided appropriate support for people who needed help to eat and drink.

People had access to health care professionals when required. Advice given by health care professionals was followed by staff to ensure that people's health care needs were fully met.

Is the service caring?

Good

The service is caring.

People who lived at the home and their relatives told us that staff were caring and we observed positive interactions between people who lived at the home and staff on the day of the inspection.

It was clear that people's individual needs were understood by staff.

We saw that people's privacy and dignity was respected by staff and that people were encouraged to be as independent as possible.

Summary of findings

Is the service responsive?

Good 

The service is responsive to people's needs.

People's care plans recorded information about their previous lifestyle and the people who were important to them. Their preferences and wishes for care were recorded and these were known by staff.

People told us they were able to take part in their chosen activities and people who were able were supported to see their relatives and friends and be part of the local community.

There was a complaints procedure in place and people told us that they were confident that any comments or complaints they made would be listened to. No complaints had been received during the previous twelve months.

Is the service well-led?

Outstanding 

The home is well led.

There was a registered manager in post at the time of the inspection.

The registered manager carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff to ensure the safety and well-being of people who lived and worked at the home.

The registered manager was enthusiastic about continually making improvements to the home and taking part in any initiatives that improved people's lives. The staff team were happy to support the registered manager with these initiatives.

There were sufficient opportunities for people who lived at the home and others to express their views about the quality of the service provided, and people felt that their views were listened to and that this led to changes being made at the home.

Lavender Court Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 26 March 2015 and was unannounced. The inspection team consisted of an Adult Social Care (ASC) inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who assisted with this inspection had experience of care settings for vulnerable people.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information from health and social care professionals. The registered provider submitted a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

Prior to the inspection we spoke with the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home. We also approached a number of social care professionals to request feedback but did not receive any responses. On the day of the inspection we spoke with six people who lived at the home, three relatives, four members of staff and the registered manager.

We looked at bedrooms (with people's permission) and communal areas of the home and also spent time looking at records. This included the care records for three people who lived at the home, the recruitment and training records for three members of staff and records relating to the management of the home.

Good

Is the service safe?

Our findings

We spoke with six people who lived at the home and they told us they felt safe living at Lavender Court. One person told us, “I have always felt safe here.” This was supported by the relatives who we spoke with. One relative told us that they were aware of fire safety due to their job. They said, “Mum is absolutely safe here. The premises are risk-free and secure too. If I had any concerns I'd raise them.”

We saw that staff induction training included information about safeguarding vulnerable adults from abuse and the training record evidenced that all staff apart from one had completed additional training. This person had, however, completed the safeguarding threshold training that had been introduced by the local authority. The registered manager told us that most staff had completed this threshold training, including ancillary staff.

Staff were able to describe different types of abuse, and were able to tell us what action they would take if they observed an incident of abuse or became aware of an allegation. Staff also told us that they had completed training on working with people with dementia. One member of staff told us, "I've had some training on working with people with dementia. I've also recently done safeguarding. That alerted us to the types of abuse and about whistleblowing."

We saw that care plans included an individual safeguarding consideration log so that any incidents could be recorded; this included a record of the use of the threshold tool introduced by the local authority and whether this indicated an alert needed to be submitted, and if a notification had been submitted to the Care Quality Commission (CQC). There was a folder ready for staff to use that contained blank safeguarding alert forms, CQC notification forms and Clinical Commissioning Group (CCG) concern report forms. This meant that staff had easy access to these forms if they needed them.

The registered manager told us that they did not use a dependency tool to determine staffing levels. She said that there was some flexibility about the number of staff on duty. For example, if someone who lived at the home was ill, they would increase staffing levels. They were able to do this because one member of staff worked partly on administration and partly as a care worker, so they were available if needed. In addition to this, the registered manager would work ‘on the floor’ and they had their own ‘bank’ staff who could cover full shifts. The registered manager told us that they only used agency staff as a ‘last resort’ as they were concerned that agency workers did not have enough knowledge to support people safely.

The standard staffing levels were two care workers and a senior care worker in a morning and two care workers in an afternoon / evening, with an additional person working from 4.30 to 6.30 pm. The registered manager worked in addition to these numbers, and the deputy manager worked as a care worker from 7.00 – 10.00 am on three days a week and for full days on two days a week

We saw that there was a cook on duty each day and either one or two domestic assistants on duty from Monday to Friday. This meant that care staff were able to concentrate on supporting and caring for the people who lived at the home.

On the day of the inspection we observed there were sufficient numbers of staff on duty to provide care and support for the sixteen people who lived at the home. However, one person who lived at the home said that they sometimes had to wait for up to 15 minutes whilst waiting for attention during the night; they said this depended which team of staff were on duty. We discussed this with the registered manager on the day of the inspection.

We saw that care plans included a ‘personal client risk assessment’. This was a document that recorded all tasks that people needed assistance with and the number of staff needed to support people with these tasks. Risk assessments had also been completed for any areas that had been identified as posing some level of risk. These included risk assessments for smoking, eating habits, vulnerability, malnutrition / dehydration and the use of alcohol. We noted that risk assessments were updated regularly to ensure that staff had up to date information to follow.

People had risk assessments in place when it had been identified that they were at high risk of having a fall. We saw that one person’s care plan recorded that a sensor alarm was being used to alert staff to when the person got out of bed; this was to reduce the risk of falls. We saw that care plans recorded specific information about how people should be supported with their mobility around the home and safe transfers. We saw that suitable equipment had

been provided for staff to ensure they were able to transfer people safely. We observed staff using an electric stand / transfer aid and how this enabled them to carry out a safe transfer. We noted that staff removed the sling from behind the person to promote their comfort and reduce the risk of pressure sores developing.

We checked the recruitment records for three new members of staff. We saw that application forms had been completed and that they recorded the person's employment history, the names of two employment referees and a declaration about whether or not they had criminal convictions. Prior to the person commencing work at the home, checks had been undertaken to ensure that people were suitable to work with vulnerable people, such as references, a Disclosure and Barring Service (DBS) first check, a DBS check and identification documents. We saw that a thorough interview had taken place to explore a person's suitability for the role they had applied for and that interview questions and responses had been retained. A number of people who lived at the home had expressed an interest in taking part in recruitment panels and this had been introduced. This meant that people took part in decision making about which applicants would be employed to work at the home.

The registered manager told us in the PIR document that they intended to require staff to undertake DBS checks every three years in future. This was to check that they continued to be suitable to work with vulnerable people.

The registered manager told us that either the deputy manager or senior care worker was responsible for holding the keys to the home each shift, including those for the medication room and cupboards. We saw that medication was stored safely and that the temperature of the medication room was taken and recorded over different times of the day to ensure that medicines were stored at the correct temperature. The home did not have a medication fridge and any medication requiring storage at a low temperature was stored in a separate plastic container in the kitchen fridge. The temperature of the kitchen fridge was taken three times each day.

Controlled drugs (CD's) were stored in a CD cabinet in the medication room. We checked a sample of controlled drugs and saw that the records in the CD book matched the number of medicines in the CD cabinet. Any unwanted medication was stored in a separate container in the medication room until it was collected by the pharmacy. We checked the records of returned medication and found these to be satisfactory.

The medication trolley was stored in the medication room and was fastened to the wall. We saw that blister packs were colour coded to identify which time of day the medicine should be administered. We observed a member of senior staff administering medication on the day of the inspection and noted that they carried out this task safely; they did not sign the MAR chart until they had seen the person take their medication. Time was spent encouraging people to take their medication if they were reluctant, and people were encouraged to take a drink after taking their medication to make sure they had swallowed it. The medication trolley was locked when unattended.

We checked medication administration record (MAR) charts and saw that they included a photograph of each person who lived at the home to aid staff, especially new staff, with identification, and information about any known allergies. The pharmacy had supplied the home with a document that recorded codes that should be used when medication had been administered, for example, if the medication had been refused. Two staff had signed hand written entries to confirm that they were correct. We saw that there were a small number of gaps in the recording of creams and inhalers.

Medication records included information about a person's latest Warfarin dose that had been faxed to the home by the GP surgery. Warfarin is an anti-coagulant drug and the dose can change frequently following the outcome of blood tests. We also saw that the registered manager had carried out an audit in November 2014 on the safe administration of Warfarin.

The staff members who were responsible for administration of medication had completed appropriate training, including all but one of the night staff team. This meant that there was always a trained member of staff on duty during the night who could administer pain relief medication if it was needed. Competency checks were carried out by the registered manager or deputy manager to ensure that trained staff remained competent to administer medication; the registered manager and deputy manager had undertaken advanced training that gave them the skills to carry out these checks.

Good

Is the service safe?

The registered manager had undertaken a baseline assessment following the National Institute for Health and Care Excellence (NICE) guidelines in respect of medication for care homes. We saw that robust medication audits were being carried out by the registered manager; this showed that medication systems were being checked regularly to ensure administration remained safe.

There had been one medication error during the previous twelve months. The registered manager had taken appropriate action but we advised them that it was good practice to submit a notification to CQC to notify us of medication errors.

There was an emergency and crisis policy in place and a business contingency plan that recorded advice for staff on how to deal with emergency situations such as a gas leak. A personal emergency evacuation plan (PEEP) had been completed that recorded the details of every person who lived at the home; this was held in the 'fire' book. We discussed this with the registered manager and it was acknowledged that the contingency plan should include a copy of the PEEP, information about people's next of kin and GP, contact numbers for staff and contractors and relocation arrangements in the event that the building needed to be evacuated. The registered manager told us that the home consisted of two properties joined together. The electricity and heating systems in each half of the home were separate, so it was unlikely that both areas would have a power failure at the same time.

We found that the premises were well maintained to ensure the safety of people who lived at the home. There was a current gas safety certificate and portable appliance test certificate in place and we saw evidence that lifts and hoists had been serviced. There was a fire risk assessment in place. However, we saw that the fire safety certificate had expired. The registered manager contacted the engineer whilst we were at the home and they apologised for not turning up on the required day. This work was carried out on 30 March 2015 and the registered manager sent us a copy of the new safety certificate.

In-house tests were carried out by the home's handyman to ensure the premises remained safe; these included tests of the fire alarm system, emergency lighting and fire drills. The registered manager told us that staff recorded any repairs that they had identified in the maintenance book and the handyman signed the book when the task had been completed. She told us that people who lived at the home also approached the handyman directly about repairs or improvements that needed to be made in their room and these were actioned.

On the day of the inspection we observed that the home was clean and free from unpleasant odours. A member of staff told us, "We make sure we have a clean, safe environment. We are aware of the need to keep fire escapes and corridors clutter-free." A person who lived at the home said, "The rooms are spotless. They are cleaned every day. The bathrooms are cleaned twice a day and they do deep cleaning every month."

We saw that there were numerous areas around the home where disposable gloves, hand disinfecting gel and disposable aprons were stored so that they were easily accessible to staff. We saw that staff used this personal protective equipment (PPE) throughout the day.

We spoke with a domestic assistant who explained the cleaning schedules and the arrangements in place to prevent the spread of infection. They told us that they had undertaken training on infection control, first aid, fire safety and health and safety. They said that there was a domestic assistant on duty on four days a week but there were two domestic staff on duty on three days a week and these were the days where they carried out deep cleans of bedrooms and communal areas of the home. They carried out between four and seven deep cleans a week so that meant that every room was done once a month. They explained the colour coding of cleaning equipment, for example, red equipment was used to clean the toilets. We checked the cleaning schedules and saw that this included lists to be used each day and signatures from staff when the tasks had been completed, including deep cleans.

We checked the infection control folder. This included a self-audit toolkit and we saw audits had been completed in January 2014 and February 2015. The outcome of both audits was 'low risk'. Any improvements needed had been highlighted, for example, the lack of nail brushes, and action had been taken. The folder also included a form to record any infection outbreaks, cleaning guides (for example, for commodes and clinical waste), guidance on infection control in care home settings and Health Protection Unit guides on infectious diseases. We asked the registered manager if they had any headboards in place that were made of fabric and therefore difficult to clean. They told us that some people had brought their own beds

Good

Is the service safe?

into the home and they had fabric headboards. They told us that they would discuss this with people who lived at the home and introduce stringent cleaning programmes if people were not willing to replace their headboards with wipeable ones.

We were told that the cook was responsible for cleaning duties in the kitchen. The home had been awarded a score of five in respect of food hygiene. This is the highest score available.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. Discussion with the registered manager evidenced that there was a clear understanding of the principles of the MCA and DoLS and they had informed us in the provider information return (PIR) that they had submitted one application to the local authority to request authorisation for a person to be lawfully deprived of their liberty. The training record evidenced that 15 of the 22 staff had completed training on the MCA. A member of staff told us, "I've had training on MCA and DoLS and best interest meetings, and we have policies and procedures on site."

We saw that each care plan had a record of the person's capacity to make decisions. One person's care plan recorded, "(The person) is capable of decision making for some day to day activities, with support. They do not have capacity for more complex decisions about their care needs. This decision was made following a capacity assessment that was completed in January 2015." When people did not have the capacity to make important decisions, we saw that a best interest meeting had been held to support the person with decision making. For example, there had been a best interest meeting to decide whether a person could be supported in the community or needed permanent residential care. Best interest meetings are held when people do not have capacity to make important decisions for themselves; health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf. Another person's care plan recorded, "It is in this person's best interests to weigh them monthly. Staff to explain to them why. If (the person) shows any signs of distress, do not weigh them that day. Contact the MDT team with any concerns on a 'need to know' basis." When we asked a relative about their involvement in best interest meetings they said, "Yes, I've been involved in those meetings. Plenty of information is provided."

When people had the capacity to consent to their care plan, to staff administering medication on their behalf and having their photograph taken, they had signed a document to evidence this. When they did not have the capacity to consent, this was recorded in their care plan. We saw one entry that recorded, "Unable to consent / sign due to lack of capacity – refer to best interest care plan."

We spoke with people about the use of restraint. No-one who lived at the home had experienced any kind of restraint and visitors who we spoke with had not observed any restraints. We saw care staff gently distracting and trying to re-focus one person who appeared a little disorientated when there was a lot of people moving around the dining room at lunchtime.

The registered manager told us that staff were applying to undertake the 'dementia friendly' training that was being provided by the local authority. Two staff had already completed a five-day training course via Bradford University on dementia care. This training enabled the two members of staff to facilitate training on personalised dementia care to the rest of the staff group. We also discussed that the Stirling University website provided helpful advice about suitable environments for people living with dementia. The registered manager told us that she planned to open a 'dementia café' at the home at some time in the future so acknowledged that this information would be useful.

The premises were also suitable for people with reduced mobility; there were ramps at entrances to the home and a passenger lift to the first floor.

We asked people who lived at the home about communication with staff. They told us, "They're very good, kind and respectful. I've never known any rudeness."

The registered manager told us in the PIR document that staff had induction training, on-going training, supervision meetings and twice yearly appraisals.

When people had previously worked in a care setting and had listed training already completed on their application form, they were required to bring copies of certificates to the home. People were still required to undertake the home's induction training programme but this information gave the registered manager an idea of the person's skill and knowledge level.

We saw that an induction checklist was completed to record the training people had completed. This recorded that people had covered the topics of infection control, the control of substances hazardous to health (COSHH), whistle

blowing, staff supervision, fire safety, personal hygiene, moving and handling, accidents / emergencies, record keeping, policies and procedures and safeguarding adults from abuse. The checklist recorded whether the person understood and could recognise signs of abuse and neglect. One new member of staff told us about their two week induction period and that they felt equipped to take on their role following this training.

Once staff had completed induction training, they completed refresher training on a variety of topics. We saw that this training was recorded in staff records and also on the overall training matrix (record). The individual records for one person listed that they had attended training on safeguarding adults from abuse, fire safety, dementia care, medication, dignity and safeguarding and the MCA in August, September or October 2014.

We checked the training matrix and saw that training courses had been recorded using different colours; red for mandatory training and yellow for desirable training. Another symbol indicated when staff had completed the safeguarding threshold training organised by the local authority; all staff apart from five had completed this training. The registered manager told us that staff were expected to complete mandatory training every year.

We saw that most staff had completed training on fire safety, safeguarding adults from abuse, first aid, medication, moving and handling, infection control, health and safety, food hygiene and MCA. Some staff were booked on training courses in March 2015; this included catheter care, moving and handling and safeguarding adults from abuse. Approximately 50% of care staff had completed some 'desirable' training; topics included Parkinson's, diabetes, DoLS, stroke awareness and equality and diversity.

In addition to mandatory and desirable training, six staff had completed National Vocational Qualification (NVQ) Level 2 in Care and five staff had completed NVQ Level 3 in Care (although some staff who had completed this award at Level 3 were the same staff who were recorded as completing Level 2). Two members of staff had requested further development and were currently undertaking Level 5 training in Health and Social Care. This showed that staff who wanted to further develop their knowledge and skills were supported by the registered manager.

Relatives and people who lived at the home told us that staff had the skills to carry out their roles. On person who lived at the home said, "The more experienced carers teach the new ones as they go. They've all been on courses" and a relative said, "Yes, they do know what they're doing. Some have had dementia and Alzheimer's training."

The staff records we checked included evidence of supervision meetings with a manager. We saw that these meetings took place approximately every two to three months. We also saw evidence that appraisal meetings were taking place. Staff were required to complete a self-assessment about their own practice as part of the appraisal process which showed they were invited to express their views and measure their own progress.

Care plans recorded when a person was at risk of dehydration or malnutrition and appropriate assessments had been carried out. One person's care plan recorded, "I require a high fat diet. I prefer desserts and will usually have a double portion. My favourites are crème meringues." The manager gave an example of one person who was at risk of malnutrition. They discovered that this person had a sweet tooth so offered them milk shakes and fruit smoothies to try to encourage them to eat and drink.

When people had been identified as being at risk of malnutrition or dehydration, food and fluid charts were being used to monitor their daily food and fluid intake. We saw that liquids were measured in millilitres (mls) so there was an accurate record of fluid intake. We saw in care plans that dieticians and other health care professionals had been consulted when people were considered to be at risk and advice was required. Any advice given had been incorporated into care plans.

People who lived at the home had meetings with the cook when their individual choices and requirements were discussed, including any allergies. This led to the menu including people's choices and also meeting their individual dietary needs. People told us they were happy with the food that was being provided. One person told us, "It's quite good. I get enough to eat and drink. There's a set menu at lunchtime. There's more choice at tea-time and you can always get tea, coffee and cake" and another person told us, "The chef will do anything we ask within reason. A lot here are old fashioned but I like something different so he does a curry or Bolognese. You see we've had input into what goes on the menu. You can get a drink or something to eat anytime."

Good

Is the service effective?

We observed the serving of lunch and saw that it was an enjoyable experience for people and that they were served with freshly cooked appetising food. We saw that tables were set with table mats, coasters, condiments and napkins to make the dining room look welcoming. There was a menu on display and this included pictures as well as a written description of the meal on offer. No-one needed assistance to eat their meal but we saw that some people needed encouragement, and this was provided appropriately by staff.

We saw that plenty of drinks were offered throughout the day and that people could also ask for a drink at any time. People who were not inclined to drink were encouraged by staff to do so.

People's health conditions had been recorded and any contact people had with health care professionals had been recorded. These records included the date, the name of the health care professional, any actions or comments and a staff signature. We saw that any advice given by health care professionals had been incorporated into care plans to ensure that staff had up to date information to follow.

People had been assessed to determine whether they needed any equipment to promote good tissue viability and we saw that this equipment had been provided when needed, such as pressure care mattresses and cushions. Body maps were included in care plans and recorded any injuries or marks on a person's body.

Some care plans included information sheets that recorded information about the person's specific health condition. For example, one care plan we saw had an information sheet about 'mixed dementia' that had been produced by the Alzheimer's society. This meant that staff had information available to them to help them to understand people's medical conditions.

Good

Is the service caring?

Our findings

We observed that there was positive and friendly interaction between people who lived at the home and staff throughout the day. People told us that staff really cared about them. One person told us, “The staff are smashing” and another said, “The care is outstanding.”

We asked staff about relationships with people who lived at the home and their relatives. One member of staff told us, “I've had meetings with the residents to get them involved in menu planning. The joking starts from the minute I walk in the door. We have lots of running jokes with a lot of the residents" and another staff member said, “The staff spend time getting to know the residents, their likes and dislikes. They're all different and we try to support them to do what they want when and how they want to. We have lots of fun. The families are as important to us too."

Relatives told us about the “Wonderful” attitude of staff. The comments we received included, “I don’t know what we would have done without them (the staff)”, “They’re excellent, above and beyond”, "Every one of them cares. They care for me too" and “I appreciate it’s not a nursing home but it hasn’t made any difference. The care has been tremendous.”

The PIR document submitted by the registered manager evidenced that there was a low turnover of staff. This helped to make sure that people received a consistent service from staff who knew them well.

Staff told us that they worked well as a team; they went on training courses together, had regular staff meetings and occasionally socialised together and this had led to a strong team ethos. They said they were “One team with one goal.” They said that staff really cared about people who lived at the home and it was “Like a family.”

We saw that people looked well dressed and cared for. Care plans included information that advised staff how people liked to be assisted with personal care. There was a record of the tasks that people would need assistance with, how many staff would be required to provide this support and the level of risk involved.

We saw that people were treated with dignity by staff and that their privacy was promoted. One person was admitted to hospital on the day of the inspection. We saw that discussions with the person and their relatives were carried out sensitively and privately to create as little anxiety as possible for the person, their relatives and other people who lived at the home.

The registered manager told us that there were six dignity ‘champions’ at the home and all staff had signed up to the Dignity challenge. All staff wore the dignity badge and discussions had been held about promoting dignity and how record keeping should reflect this.

On the day of the inspection we saw that staff knocked on doors before entering. We also saw the person administering medication discreetly asked people about their need to take ‘as and when required’ (PRN) medication. However, one person told us that staff were not very discreet when asking people about their medication needs whilst in the dining room and that this could cause embarrassment.

The PIR document recorded that six people who lived at the home had “Do Not Attempt Resuscitation” (DNAR) notices in place. The DNAR notices we saw had been completed correctly and the relevant people had been consulted, including the person concerned when this had been appropriate. We saw that one care plan recorded, “Not for DNAR although staff must follow procedures and call 999 without delay, and explain symptoms and state that they are not for resuscitation.”

We saw that a person’s care plan recorded their wishes for end of life care when this had been discussed with them. One care plan that we saw recorded, “(Name) has full capacity to make decisions. (Name) requests to stay at Lavender Court and does not want to go into hospital for any reason at all. Family and GP aware of (name) decision.”

We saw that appropriate pressure care equipment had been obtained for people who remained in bed or spent long times of the day in bed. People were also repositioned regularly to alleviate the risk of pressure sores developing and hydration was encouraged; these inputs from staff were recorded appropriately. We saw that the GP had visited people who were at the end of their life on a regular basis and any advice given had been recorded by staff. Key drugs had been delivered to the home so that they were available should they be needed quickly or ‘out of hours’.

Good

Is the service caring?

We saw that people had patient passports in place. These are documents that people can take to hospital with them to inform hospital staff about their specific care needs when they are not able to communicate this information themselves.

Good

Is the service responsive?

Our findings

Care needs assessments had been completed prior to the person's admission to the home. Areas covered included medication, current health needs, dietary needs, communication, mobility needs, social activities and pressure care. This information had been used to develop an individual plan of care.

All of the people we spoke with on the day of the inspection were aware of their care plan. We saw that care plans were based on the individual needs of the person concerned. They included sections entitled, "All about me", "What's important to me" and "Things that will make my life better." They also included information about the person's life history so that staff had more knowledge of the person's life prior to their admission to the home; this helped staff to build relationships with people and to meet their individual needs and preferences.

Each care plan area was recorded as "The current situation / aim / action / evaluation and outcome." Personalised information was recorded such as, "I like my bath in an evening", "I like to choose my own clothes" and "I enjoy sitting outside in the garden in good weather and I like to smell the flowers." People who we spoke with felt their care was personalised and this was supported by the relatives who we spoke with. One relative told us, "It's a home from home. The care is personal to each resident and family. They can't do enough." Another relative said, "They've taken the time to find out about (our relative) and then to meet their needs." However, one person who lived at the home told us that care was not so person-centred during the night when there were only two staff on duty.

We saw that care plans were evaluated each month and that any changes made to the care plan were signed and dated so that it was clear when any changes had occurred and that staff had up to date records to follow. People who lived at the home and relatives told us that they were involved in care plan reviews.

The home employed an activities coordinator on two afternoons a week. Other entertainers also came into the home. There was a motivation class each Friday afternoon and on the day of the inspection there was a singer entertaining people, including relatives, for most of the afternoon. Family and friends were invited to some activities; there was a 'Pig Bingo' session planned for the following Friday night. There were two lounges; one where the TV was on for most of the day and one where people mainly listened to music (although there was a TV so that people could watch different channels).

We saw that a survey had been produced ready for distribution to ask people for their opinions about the activities in place at the home. A relative told us, "There's all sorts of activities. Families and friends get involved. There's singing, quizzes, skittles, exercise and crafts. There was a successful bowling team and I think they'll do it again this year."

The registered manager told us that people who lived at the home were involved in planning the garden and in producing home grown vegetables. Some activities were personalised, for example, one person enjoyed gardening and another enjoyed baking, and these activities were included in activity plans. The registered manager believed that this one to one attention had improved the well-being of the people concerned.

We spoke to one person who was listening to a CD of the local newspaper in the lounge. They told us that the home received this every week and that this kept them up to date with what was happening in the local area. They told us that some of the staff were from the village and they kept them up to date with local events. This person and a member of staff told us that the home had won the village Scarecrow competition.

People told us that their family and friends were able to visit them at any time and were always made welcome. A staff member told us, "We encourage contact. We try to keep them involved in community activity – local groups and events, and church if they're used to going."

People who we spoke with told us that they were provided with ample information. One relative told us, "The staff keep me fully informed about mum's health. They will ring me at home – they don't just wait until I come in to see her."

The quality assurance policy recorded, "Service users should be free to complain about any aspect of running the home." There were policies and procedures in place to inform people about the complaints procedure, and notices on display to remind people that they were free to raise complaints or concerns. There had been no complaints raised during the previous year.

Good

Is the service responsive?

One visitor told us that they had previously made a complaint about staff not changing their relative's bed. They said that it was dealt with immediately. People who lived at the home told us that they were able to speak freely and express their views. One person said, "I spoke out about the menu and they listened." This shows that people were confident about making a complaint and that it would be dealt with satisfactorily by the registered manager.

Outstanding ☆

Is the service well-led?

Our findings

We saw that surveys had been sent out to people who lived at the home, relatives and friends, staff and visiting professionals to gain people's opinions about the service provided by the home.

In November 2014, 16 surveys had been distributed to people who lived at the home and twelve had been returned. They were asked questions about privacy and dignity, making a complaint, communication with staff, the atmosphere of the home and access to specialist health care professionals. Questions included, "Do staff demonstrate clear understanding of your needs?" and "Do you feel the staff are professional?" The responses had been collated and we noted that all responses were positive.

Fifteen surveys had been given to visiting professionals and five had been returned. Again, responses were positive. Professionals said that they had never received any complaints about the home, that there was always someone to assist them when they visited the home and that the staff were always respectful and considerate towards the people who lived at the home. They were asked, "Do staff demonstrate a clear understanding of the care needs of service users?" The responses were 60% 'always' and 40% 'usually'.

We looked at the surveys returned by relatives and staff and noted that these were also positive. The registered manager told us that staff surveys were anonymous and that they believed this demonstrated open and transparent working relationships. This view was supported by staff who we spoke with.

The registered manager told us in the PIR document that they intended to introduce a suggestion box so that people could leave comments anonymously if they preferred.

The local authority that commissions a service from the home had undertaken a quality monitoring visit to the home and we saw the report sent to the home following the visit. This recorded positive outcomes for people who lived at the home. People who we spoke with on the day of the inspection told us they would recommend the home. Two relatives told us that they already had.

'Residents' meetings were held at the home. We looked at the minutes of the meeting held on 2 January 2015. The topics discussed included food provision, Christmas, current entertainment (people were asked which entertainers they enjoyed so that they could be booked again), fund raising and care. People who attended the meeting stated that they had no problems in respect of the care provided and they were complimentary about care staff. At the previous meeting in October 2014 people had complimented the new personalised menu and said how much they were enjoying the meals.

We saw that staff meetings were held on a regular basis. We looked at the minutes of the meeting that was held in January 2015. Previous meetings had been held in May, July and October 2014. The topics discussed in January 2015 included the use of Facebook, nail care, staff breaks, appraisals, fund raising, infection control, uniforms and quality assurance feedback. This included feedback from all of the surveys carried out in November 2014 and from the quality monitoring visit by the local authority. Staff told us that they were able to contribute to staff meetings and were listened to.

We saw that a night staff meeting was held on the evening of the same day. The same topics were discussed with night staff. This ensured that all staff had been given the same information and all staff had been given an opportunity to express their views about the topics discussed.

The registered manager had produced a checklist called "Improving as a Learning Organisation". One question listed was, "What should the home or organisation be known for?" and the response, "Being able to actively listen and involve residents and employees in the home's decisions to improve the organisation."

The registered manager had carried out a number of audits to monitor that systems in place were being followed by staff. We saw that care plan audits were being undertaken and that any shortfalls were recorded and actioned. One person's care plan audit recorded, "Nutritional and waterlow risk assessment needs evaluating and changing. Actioned immediately." Approximately three care plans were being audited each month. An audit had been carried out in respect of fire safety in March 2013 and this had been reviewed in April 2014, infection control audits had been carried out on a regular basis and medication audits were being carried out monthly.

Outstanding ☆

Is the service well-led?

Accidents and incidents were recorded and audited. We saw that the accident form recorded whether urgent or non-urgent medical attention had been sought. These records were monitored continually but every three months this information was monitored more closely to identify whether anyone needed to be referred to the falls team or any other concerns needed to be explored further.

We asked the registered manager if they had received any awards or other kinds of recognition. She told us that a member of staff had undertaken a 'bronze' award in Nutrition Mission via Humber NHS Foundation Trust and they were waiting for the outcome of their assessment in respect of the 'silver' award. Their success had been reported in the local press. The registered manager said that they were already working towards the gold and platinum awards even though these were not yet in place. Lavender Court was the only service in the area to achieve this award. As part of this incentive, people who lived at the home were growing their own vegetables and these were been prepared by the cook. Those people who wanted to be more independent were served part of their meal in tureens so that they could serve themselves. Staff had noted that some people had gained weight as a result of the milk shakes and fruit smoothies that had been introduced, and that this had been particularly beneficial for people living with dementia.

We asked visitors to the home what they thought about the culture and values. One relative told us, "It's progressive – they want to do lots of new and different things with the residents. It's a lovely place" and another one said, "It's warm, welcoming, open and inclusive." We asked staff the same question. Their comments included, "It's friendly and very open with excellent management. They're very caring and accommodating to everyone. The best I've worked for" and "It's nice and open. Everyone is treated equally and valued. The management is very good. Very supportive."

There were other examples of excellent practice; some of the people who lived at the home were involved in the recruitment and selection of staff and all staff had signed up to the Dignity challenge. The registered manager told us that they had supported one person to return home after a period of respite care at Lavender Court. They had liaised with various support services to make this transition back home successful.

Staff 'champions' had been identified. Champions are staff members who take on responsibility for a particular topic. It is their role to share up to date information with the rest of the staff group and to promote their topic within the home. Rather than having one champion per topic, there were three moving and handling champions and six dignity champions at the home. There were plans to introduce champions for other topics.

A member of staff told us that the registered manager had an "Open door policy" and that they could talk to her at any time about issues or concerns. They said that all staff and some of the people who lived at the home had the registered manager's mobile telephone number and that "She was available 24/7."