Mr & Mrs K R Webb

Lavenders

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 12 April 2016 and was unannounced.

Lavenders is a privately owned care home for up to 59 older people who require accommodation and personal care. The property is a detached older house, to which large extensions have been added. The accommodation is divided into wings. These are called Regency, Lavinia and Boswell. At the time of our visit, there were 50 people who lived in the home. People had a variety of complex needs including onset of dementia, physical health needs and mobility difficulties.

There was a registered manager at the home. 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.

Training records showed that not all staff had completed training in a range of areas that reflected their job role, such as essential training they needed to ensure they understood how to provide effective care, and support for people. There were gaps in the training schedule which showed that not all staff had completed safeguarding, Deprivation of Liberty Safeguards (DOLS), Mental Capacity Act (MCA).

The provider had systems in place to manage safeguarding matters and make sure that safeguarding alerts were raised with other agencies. All of the people who were able to converse with us said that they felt safe in the home; and said that if they had any concerns they were confident these would be quickly addressed by the registered manager. Relatives felt their people were safe in the home.

The home had risk assessments in place to identify risks that may be involved when meeting people's needs. The risk assessments showed ways that these risks could be reduced. Staff were aware of people's individual risks and were able to tell us about the arrangements in place to manage these safely.

There were sufficient numbers of qualified, skilled and experienced staff to meet people's needs. Staff were not hurried or rushed and when people requested care or support, this was delivered quickly. The provider operated safe recruitment procedures.

Medicines were stored and administered safely. Clear and accurate medicines records were maintained. Staff knew each person well and had a good knowledge of the needs of people who lived at the home.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards and the home complied with these requirements.

The food menus offered variety and choice. They provided people with nutritious and a well-balanced diet. The chef prepared meals to meet people's specialist dietary needs.

People were involved in their care planning, and that staff supported people with health care appointments and visits from health care professionals. Care plans were amended immediately to show any changes, and care plans were routinely reviewed every month to check they were up to date.

People were treated with kindness. Staff were patient and encouraged people to do what they could for themselves, whilst allowing people time for the support they needed. Staff encouraged people to make their own choices and promoted their independence.

People knew who to talk to if they had a complaint. Complaints were managed in accordance with the provider's complaints policy.

People's needs were fully assessed with them before they moved to the home to make sure that the home could meet their needs. Assessments were reviewed with the person and their relatives. People were encouraged to take part in activities and leisure pursuits of their choice, and to go out into the community as they wished.

People spoke positively about the way the home was run. The management team and staff understood their respective roles and responsibilities. Staff told us that the registered manager was very approachable and understanding.

There were effective systems in place to monitor and improve the quality of the service provided. We saw that various audits had been undertaken.

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.

The provider had taken necessary steps to protect people from abuse. Risks to people's safety and welfare were assessed and managed effectively.

There were enough staff employed to ensure people received the care they needed and in a safe way.

There were effective recruitment procedures and practices in place and being followed.

Medicines were safely stored and administered to people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received regular supervision from their line manager to ensure they had the support to meet people's needs. Not all staff had been trained in key specialised trainings required to adequately meet people's needs.

People's rights were protected under the Mental Capacity Act 2005 (MCA) and best interest decision made under the Deprivation of Liberty Safeguards (DoLS).

People were supported effectively with their health care needs.

People were provided with a choice of nutritious food.

Is the service caring?

Good

The service was caring.

The registered manager and staff demonstrated caring, kind and compassionate attitudes towards people.

People's privacy was valued and staff ensured their dignity.

People and relatives were included in making decisions about

their care. The staff in the service were knowledgeable about the support people required and about how they wanted their care to be provided.

Is the service responsive?

Good

The service was responsive.

People's needs were fully assessed with them before they moved to the home to make sure that the staff could meet their needs.

The management team responded to people's needs quickly and appropriately whenever there were changes in people's need.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Good

The service was well led.

The home had an open and approachable management team. Staff were supported to work in a transparent and supportive culture.

The provider had a clear set of vision and values, which were used in practice when caring for people.

There was a robust staffing structure in the home. Both management and staff understood their roles and responsibilities.

There were effective systems in place to monitor and improve the quality of the service provided.

Lavenders

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 12 April 2016 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We looked at previous inspection reports and notifications about important events that had taken place in the home, which the provider is required to tell us by law. We used all this information to decide which areas to focus on during our inspection.

Not everyone was able to verbally share with us their experiences of life at the service. This was because of their complex needs. We therefore spent time observing people and how care was delivered and 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 with us.

However, we were able to speak with three people, four relatives, two care staff, three senior care staff, the activity coordinator, chef, deputy manager and the registered manager. We also requested information from healthcare professionals involved in the home. These included professionals from the community heart failure specialist nurses, NHS and the GP.

We looked at the provider's records. These included four people's records, which included care plans, health care notes, risk assessments and daily records. We looked at five staff files, a sample of audits, satisfaction surveys, staff rotas, and policies and procedures. We also looked around the care home and the outside spaces available to people.

At our last inspection on 24 October 2013, we had no concerns and there were no breaches of regulation.

Good

Is the service safe?

Our findings

Our observation showed that people were safe at the home. Relatives felt their family members were safe in the home. One relative said, "I can't fault them. They give me confidence. If mum see a doctor or someone, they call me". Another relative said, "Always clean and tidy. Always enough staff" and "I like to know mum is safe. It has been marvellous".

A healthcare professional commented, 'I have visited Lavenders on approximately 5-6 occasions to visit one patient with a diagnosis of heart failure. During these visits I have never had any concerns regarding the care received and feel it is safe'.

The provider had taken reasonable steps to protect people from abuse. There were systems in place to make sure that safeguarding alerts were raised with other agencies, such as the local authority safeguarding team, in a timely manner. Care staff told us they would tell the manager or deputy manager of any safeguarding issues.

Staff told us that they had received safeguarding training at induction and we saw from the training records that all staff had completed safeguarding training within the last two years. The staff we spoke with were aware of the different types of abuse, what would constitute poor practice and what actions needed to be taken to report any suspicions of abuse that may occur. A member of staff said, "Safeguarding is about keeping people safe from abuse. If I am concerned or witnessed any abuse, I will report it to my line manager". Staff told us the registered manager would respond appropriately to any concerns. Staff knew who to report to outside of the organisation and gave the example of CQC. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. The home had up to date safeguarding and whistleblowing policies in place. These policies clearly detailed the information and action staff should take, which was in line with expectations. This showed that the provider had systems and processes in place that ensured the protection of people from abuse.

People had individual care plans that contained risk assessments which identified risk to people's health, well-being and safety. Risk assessments were specific to each person. Staff told us they were aware of people's risk assessments and guidelines in place to support people with identified needs that could put them at risk, such as diabetes. Risk assessments were regularly reviewed and updated in line with people's changing circumstances. For example, where people were identified as at risk of fall, specialist equipment such as shower chairs had been obtained. Guidance was provided to staff on how to manage identified risks. This ensured staff had all the guidance they needed to help people to remain safe.

We spoke with both the deputy manager and the registered manager about how risks to people's safety and well-being were managed. They both were able to tell us how they put plans in place when a risk was identified. The deputy manager described the action they had taken to minimise the risk of falling for one

person who had had a number of falls. There was a clear plan in place which staff were aware of and used.

Staff maintained an up to date record of each person's incidents or referrals, so any trends in health and behaviour could be recognised and addressed. Records of each referral to health professionals were maintained, and used to build up a pattern which allowed for earlier intervention by staff. For example, staff sought advice from occupational therapists about the use of moving and handling equipment to support people. Staff we spoke with told us that they monitored people and checked their care plans regularly, to ensure that the support provided was relevant to the person's needs. The staff members were able to describe the needs of people at the home in detail, and we found evidence in the people's support plans to confirm this. This meant that people at the home could be confident of receiving care and support from staff who knew their needs.

There were suitable numbers of staff to care for people safely and meet their needs. The registered manager showed us the staff duty rotas and explained how staff were allocated to each shift. The rotas showed there were sufficient staff on shift at all times. We also observed that there were sufficient staff on duty to meet people's needs, for example supporting people attending hospital appointments on an individual basis. The registered manager said that if a member of staff telephones in sick, the staff in charge would contact their bank staff team to find cover. This showed that arrangements were in place to ensure enough staff were made available at short notice. The registered manager told us that the roster is based on the needs of people. Staffing levels were regularly assessed depending on people's needs and occupancy levels, and adjusted accordingly. Provider's policy stated 'Lavender uses a systematic approach based upon the number of residents, their care and treatment needs and their overall dependency'. This demonstrated that both the provider and registered manager had staffing levels based on people's needs in order to keep them safe.

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Appropriate checks were undertaken and enhanced Disclosure and Barring Service (DBS) checks had been completed. The DBS checks ensured that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and staff did not start working alone before all relevant checks had been completed. Staff we spoke with and the staff files that we viewed confirmed this. This meant people could be confident that they were cared for by staff who were safe to work with them.

People were protected from the risks associated with the management of medicines. People were given their medicines in private to ensure confidentiality and appropriate administration. The medicines were given at the appropriate times and people were fully aware of what they were taking as staff explained this to them. We observed a senior care staff administering people's medicines during the home's lunchtime medicine round. The senior care staff checked each person's medication administration record (MAR) prior to administering their medicines. The MAR is an individual record of which medicines are prescribed for the person, when they must be given, what the dose is, and any special information. People were encouraged to be as independent as possible with their medicines. Medicines were given safely.

The home encourages self-administration of medicines. People who self-administered their own medicines had staff completed checks to ensure these were being taken in line with the prescription. Detailed records were made and kept when people were supplied with medicines for self-administration and when they took their medicines themselves. Administration risk assessments were in place and duly completed. The home had a 'self-medicating resident compliance form' completed as stated in their policy monthly. This was to ensure that medicines were taken as prescribed.

Medicines were kept safe and secure at all times. Unwanted medicines were disposed of in a timely and safe manner. A lockable cupboard was used to store medicines that were no longer required. Accurate records were kept of their disposal with a local pharmacist and signatures obtained when they were removed. We saw records of medicines disposed of and this included individual doses wasted, as they were refused by the person they were prescribed for. Fluid thickener, which was used to thicken drinks to help people who have difficulty swallowing, was kept locked away in the cupboard in another locked storage room for safety. This demonstrated that the provider ensured medicines were kept safe.

There was a system of regular audit checks of medication administration records and regular checks of stock. The registered manager and deputy manager conducted a monthly audit of the medicine used. This indicated that the provider had an effective governance system in place to ensure medicines were managed and handled safely.

Each care plan folder contained an individual Personal Emergency Evacuation Plan (PEEP) reviewed in 2015. The fire safety procedures had been reviewed and the fire log folder showed that the fire risk assessment was recently reviewed in 2016. Fire equipment was checked weekly and emergency lighting monthly. Fire drills took place monthly and those present people staff recorded. Staff had completed a fire competency assessment.

There was a plan for staff to use in the event of an emergency. This included an out of hour's policy and arrangements for people which was clearly displayed in care folders. This was for emergencies outside of normal hours, or at weekends or bank holidays. The staff we spoke with during the inspection confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. We found that staff had the knowledge and skills to deal with all foreseeable emergencies. Both the registered manager and the deputy manager worked alternate weekends to support the staff.

The design of the premises enhanced the levels of care that staff provided because it was specious, well decorated and had been suitably maintained. Corridors were spacious with good lighting and was very clean and fresh.

Requires Improvement

Is the service effective?

Our findings

Relatives said, "My mother in law has a new lease of life after coming here. She speaks very highly of the home." and "There is someone always accessible, including weekends".

A Healthcare professional commented as follows, 'I have to communicate with the home with regards to appointments and changes of treatment and this has been most effective with no problems to identify'.

All staff completed training as part of their probationary period. New staff had provider's comprehensive induction records which they worked through during their probationary period. Staff told us that they were mentored by both deputy manager and the registered manager to help them to complete their induction. Staff were confident that by the end of their induction period they had attained the skills and knowledge to be able to care for the people living in the home. These skills were built upon with further experience gained from working in the home, and through further training. Staff told us that their training had been planned and that they could request further specialist training if needed.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people living in the home. Some staff had completed vocational qualifications in health and social care. These are work based awards that are achieved through assessment and training. To achieve a vocational qualification, candidates must prove that they have the competence to carry out their job to the required standard. This allowed management to ensure that all staff were working to the expected standards, caring for people effectively, and for staff to understand their roles and deliver care effectively to people at the expected standard. Staff received refresher training in a variety of topics, which included health and safety, fire safety, safeguarding and food hygiene.

However, the staff training plan given to us showed that not all staff had been trained on essential training they needed to ensure they understood how to provide effective care, and support for people. There were gaps in the training schedule which showed that 10 out of 65 staff had not completed safeguarding training and 31 out of 65 staff had not completed Deprivation of Liberty Safeguards (DOLS) training. None of the staff had been trained on Mental Capacity Act (MCA). The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over. This meant that not all staff had received training to understand the MCA principles and how to apply them in practice and adequately meet people's needs.

Members of staff felt supported by the registered manager, however one to one formal supervisions had not regularly taken place. Out of the five staff files we looked at, one person had their last one to one formal supervision on 15 September 2015, another had their last supervision on 05 November 2014 and the third staff had not received any supervision since they started in December 2015. Members of staff spoken with told us that they do have supervision but cannot remember the date. A member of staff said, "If I have any problem, I will speak with the registered manager. I think my supervision is due. I had one a year ago". The registered manager confirmed that they had identified gaps in staff supervision and are working on it. The provider's supervision procedure stated, 'All care staff requires formal supervision 6 times a year. All kitchen

housekeeping staff require formal supervision 4 times a year'. This showed that the registered manager had not complied with their own procedure regarding staff supervision.

Staff had not received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Yearly appraisals were carried out and reviewed. The last time this took place, development & training needs were identified. Tasks to be carried out were also identified with timescales for completion. For example, one member of staff was identified to benefit from additional training. This was actioned and planned for by the registered manager. This would enable staff to improve on their skills and knowledge which would ensure effective delivery of care to people.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. Guidance was included in the policy about how, when and by whom people's mental capacity should be assessed. One staff member explained that every person has some capacity to make choices. They gave us examples of how they supported people who did not verbally communicate to make choices. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. None of the people in the home was currently subject to a DoLS. The registered manager understood when an application should be made and how to submit one and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

Before people received any care or treatment they were asked for their consent. Staff interacted well with people, and asked them where they wanted to go and what they wanted to do. They obtained people's verbal consent to assist them with personal care such as helping them with their meals, or taking them to the toilet. Staff were aware of how to treat people with respect and that they allowed people to express their consent to different tasks. There were consent forms in place in each person's care plan. Consent forms had been appropriately completed by people's representatives where this was applicable. The forms showed the representative's relationship to the person concerned, and their authorisation to speak or sign forms on the person's behalf or in their best interests.

The risks to people from dehydration and malnutrition were assessed so they were supported to eat and drink enough to meet their needs. Records of allergies were kept in people's care plans. For example, one person was allergic to fish. We saw this in the kitchen food plan adhered to by the kitchen staff. People who had been identified as at risk had their fluid and food intakes monitored and recorded. Staff responded to concerns about people's weight or fluid intake by seeking advice and additional support from people's general practitioner (GP), specialist nurses and dieticians. For example, one person was provided with a soft diet and staff helped them while eating to ensure risks of choking were reduced. Hot and cool beverages and snacks were offered to people by staff twice a day and upon request.

Staff told us how they encouraged people to eat and drink. One said, "If someone did not eat their food I would always go back and offer them something different." Another said, "People get plenty of food and they are offered snacks and at other times"; "People can get food and drink during the night if they want it, like tea and toast". We observed that people who were awake early in the morning were offered drinks and snacks.

People and relatives were very positive about the quality of the food, choice and portions. One relative said, "Food here are freshly cooked" and another said "Really excellent food". We observed lunch in the dining

room where all the people were offered a choice. The food looked and smelt appetising and the portions were generous. Staff worked with the cook as team to ensure meals were delivered quickly and hot. Special requests and special dietary requirements were plated up separately. Other options were immediately available should anyone change their mind or want something not on the menu. There was a pleasant atmosphere in the dining room and it was evident that people enjoyed the food. The cook was aware of the dietary requirements of people and she was very actively involved in the delivery of the food and service. Diabetic desserts were available for those with diabetes. The cook told us that they provided variety of food and special needs/requests such as soft diet like pureed food and diabetic diet for diabetic people are taken care of. This showed that staff ensured people's specific nutritional needs were met.

People or their representatives were involved in discussions about their health care. A relative said, "Staff ring me if there are any problems. They always had the GP in if there any problem or incident". The GP visited the home every Friday and when requested in an emergency. People's treatment was reviewed and changed if necessary according to their medical condition. The community nurses and other healthcare professionals supported the home regularly. A healthcare professional said, "I have found the staff to be always helpful and co-operative in achieving the best individual care and ensuring that any specific health needs are met".

Records confirmed that there were systems in place to monitor people's health care needs, and to make referrals within a suitable time frame. The health records were up to date and contained suitably detailed information. Staff implemented the recommendations made by health professionals to promote people's health and wellbeing. Staff described the actions they had taken when they had concerns about people's health. For example, they maintained soft diets for people with swallowing difficulties and repositioned people who were cared for in bed on a regular basis to minimise the risk of pressure ulcers developing.

Good

Is the service caring?

Our findings

People told us that staff were caring. One person said, "I am happy here. Staff are lovely" and "Staff are kind and caring. They knock on doors".

Relative commented as follows, "The home is welcoming environment and very open.", "My mum speaks very highly of the home.", "We feel pleased mum is here".

A healthcare professional commented, 'I have always found the staff very helpful and accommodating'.

We spent time and observed how people and staff interacted. Staff were seen to be kind and caring throughout our visit. The care that was provided was of a kind and sensitive nature. Staff responded positively and warmly to people. Staff checked on people's welfare when they preferred to remain in their bedroom or not to take part in the activities. Staff provided reassurance for a person who was anxious during mealtime. A member of staff sat next to them gently speaking and feeding the person, which provided comfort and reassurance. This showed that staff were knowledgeable about how to care for the person.

People were supported to make sure they were appropriately dressed and that their clothing was arranged to ensure their dignity. Staff were seen to support people with their personal care, taking them to their bedroom or the toilet/bathroom if chosen.

Staff provided clear explanations to people before they intervened, for example when people were helped to move from an armchair to their wheelchair using specialised equipment. Staff checked at each stage of the process that people were comfortable and knew what to expect next. People were presented with options, such as participating in a group or one to one activity, have a cup of tea, read their newspaper or walk with the staff. Staff checked with people if they wished to visit the toilets at regular intervals and offered to accompany them. We observed that staff were interested in what people had to say and were actively listening to them.

The staff promoted independence and encouraged people to do as much as possible for themselves. People were dressing, washing and undressing themselves when they were able to do so. They had choice about when to get up and go to bed, what to wear, what to eat, where to go and what to do according to their care plan. Their choices were respected. Staff were aware of people's history, preferences and individual needs and these were recorded in their care plans. Times relating to people's routine were recorded by staff in their daily notes. As daily notes were checked by senior staff any significant changes of routine were identified and monitored to ensure people's needs were met.

People were able to spend private time in quiet areas when they chose to. Some people preferred to remain in a quieter sitting area when activities took place in the main lounge. For example, one person came to sit next to inspectors in the conservatory and chatted with us. This showed that people's choices were respected by staff.

Staff addressed people by their preferred names and displayed a polite and respectful attitude. They knocked on people's bedroom doors, announced themselves and waited before entering. People chose to have their door open or closed and their privacy was respected. People were assisted with their personal care needs in a way that respected their dignity. Staff covered people with blankets when necessary to preserve their dignity.

People were involved in their day to day care. People's relatives or legal representatives were invited to participate each time a review of people's care was planned. People's care plans were reviewed monthly by senior staff or whenever needs changed.

The registered manager told us that advocacy information was available for people and their relatives if they needed to be supported with this type of service. Advocates are people who are independent of the home and who support people to make and communicate their wishes. People told us they were aware of how to access advocacy support. Advocacy information was on the notice board for people in the home.

Good

Is the service responsive?

Our findings

One person said, "we have good level of activities here every day. I enjoy gardening and we have a gardening club".

Relatives commented, "We can't fault them. I can go to the office and they give me confidence. They listen to us and act upon it. Nothing is too much" and "Absolutely brilliant, nice environment, clean and plenty of activities".

People's individual assessments and care plans were reviewed with their participation or their representatives' involvement. A relative told us, "We are informed and involved every step of the way".

Each person's physical, medical and social needs had been assessed before they moved into the service and communicated to staff. Pre-admission assessment of needs included information about people's life history, likes, dislikes and preferences about how their care was to be provided. Care plans were developed and maintained about every aspect of people's care and were centred on individual needs and requirements. This ensured that the staff were knowledgeable about people's individual needs from the onset.

People's care plans included risk assessments with clear recommendations to staff about how to reduce the risk that was identified. A person who experienced falls was provided with equipment that alerted staff when they stepped out of bed so they could provide help and reassurance. People were placed under observation following a fall and their progress was recorded. If needed they are referred to the 'falls clinic'. Care plans were reviewed monthly or as soon as people's needs changed and were updated to reflect these changes to ensure continuity of their care and support. For example, a care plan had been updated to reflect a change of medicines following a G.P.'s visit and a review of their care. This showed that management and staff responded to people's changing needs whenever required.

Staff ensured that people's social isolation was reduced. Relatives and visitors were welcome at any time and were invited to stay and have a meal with their family member. A relative said, "We are encouraged to keep in contact by phone, visits, meals and birthday celebrations.

We found that staff worked in a variety of ways to ensure people received support they needed. Equality and diversity was covered in people's care plans and it details people's preferences and individuality. For example one person likes to be called a certain name at certain times and other times, another name. One person said, "They call us by our Christian names, which is good". We observed that staff called them these preferred names. Religious and cultural needs are also taken into consideration. People attended church services of their faith when they wished. The home holds a weekly communion service for those who wish to attend. We observed this during our visit. This showed that people were given the opportunity to express their faith. This showed that staff supported people based on the person's choice and preference.

People were able to express their individuality. Bedrooms reflected people's personality, preference and

taste. For example, some rooms contained articles of furniture from their previous home, life history and people were able to choose furnishings and bedding. This meant that people were surrounded by items they could relate with based on their choice.

Activities took place daily. The activities coordinator consulted people and took their preferences and suggestions in consideration before planning the activities programme. There were group activities and one to one sessions for people who preferred or who remained in their room. Activities included card games, identification of photographs and reminiscence, bowling, exercise, music, dancing and arts and craft. One to one sessions included arms and hands massages, reading aloud and sing-along. The activities coordinator organised activities for each month. During our visit, an activities coordinator carried out hairdressing for people. The activities coordinator told us that this took place two days every week.

There was a weekly activities timetable displayed in people's care files and people confirmed that activities were promoted regularly based on individual's wishes. There was also a monthly activities newsletter which was displayed on the notice board. The newsletter referred to various activities for each month such as 'cooking club, flowering arranging club, gardening club and quiz afternoon'. Activities were person-centred. Monthly activities newsletter were also issued to each resident at the beginning of each month. People were able to express their wishes and choices though their interests.

The provider contacted other services that might be able to support them with meeting people's mental health needs. This included the local authority's community
Mental Health team. Details of Speech and Language Therapist (SALT) referral and guidance was in place demonstrating the provider promoting people's health and well-being. Information from health and social care professionals about each person was also included in their care plans. There were records of contacts such as phone calls, reviews and planning meetings. The plans were updated and reviewed as required. Contact varied from every few weeks to months. This showed that each person had a professional's input into their care on a regular basis.

The provider used an annual questionnaire to gain feedback on the quality of the service. These were sent to people living in the home, staff, health and social care professionals and relatives. The registered manager told us that completed surveys were evaluated and the results were used to inform improvement plans for the development of the home. The relatives feedback received for 2015 were generally positive. Where needed action plans had been developed to provide for suggestions made. For example, more dementia friendly activities were requested for. We found that the registered manager had reviewed all activities and employed a new activities coordinator as a result.

The complaints process was displayed in one of the communal areas so all people were aware of how to complain if they needed to. The information about how to make a complaint had also been given to people when they first started to receive the service. The information included contact details for the provider's head office, social services, local government ombudsman and the Care Quality Commission (CQC). Three complaints were received in the last 12 months before this inspection. All were satisfactorily resolved by the registered manager.

Staff told us that they would try to resolve any complaints or comments locally, but were happy to forward any unresolved issues to the registered manager. People told us that they were very comfortable around raising concerns and found the registered manager and staff were always open to suggestions; would actively listen to them and resolved concerns to their satisfaction. A relative told us, "If I had reason to complain I would just talk with the manager and this will be sorted straight away". We saw complimentary messages sent to the registered manager and staff. These included comments such as, 'Thank you to you

and everyone that cared for dad over the past year. You allowed us to feel that he was in safe hands' and 'To all the lovely staff who have looked after our mum over the last five years. Thank you so much for your kindness and wonderful care for dad'.

Good

Is the service well-led?

Our findings

Relatives told us that the registered manager was very approachable and responsive. They said, "The home is welcoming environment and very open".

The registered manager inspired the staff to maintain excellent standards of practice by setting an example for staff to follow. The staff told us, "She is approachable; I can go to her at any time", "We work as a team, we support each other" and "They give us information and guidance. We get support from them. I can walk into their office at any time, I mean the registered manager, deputy manager and the provider.

The provider had a clear set of vision and values. These stated 'To provide the highest possible professional care in a warm and friendly environment with a home from home feel for the older people'. Our observations showed us that these values had been successfully cascaded to the staff who worked in the home. Staff demonstrated these values by meeting people's needs based on their assessed needs. People told us that it is a home from home for them. A relative said, "My mother in law has a new lease of life after coming here and we are happy".

The management team at Lavenders included the registered manager and the deputy manager. Support was provided to the registered manager by the provider who has an office on the premises, in order to support the home and the staff. The registered manager oversaw the day to day management of the home. Both the registered manager and deputy manager knew each resident by name and people knew them and were comfortable talking with them. The registered manager told us they were well supported by the provider who provided all necessary resources necessary to ensure the effective operation of the service. We observed the presence of the provider in the home and found people chatting with them. This showed that the registered manager and staff were well supported by the provider.

Staff understood their roles and responsibilities and told us they worked well as a team. They were able to describe these well and were clear about their responsibilities to the people and to the management team. The staffing and management structure ensured that staff knew who they were accountable to.

Communication within the home was facilitated through weekly and monthly management meetings. This provided a forum where clinical, maintenance, catering, activities and administration lead staff shared information and reviewed events across the home. Staff told us there was good communication between staff and the management team.

The home worked well with other agencies and services to make sure people received their care in a cohesive way. Healthcare professionals we contacted told us that the home always liaised with them. A healthcare professional told us that staff at Lavenders worked well with them at all times. This showed that the management worked in a joined up way with external agencies in order to ensure that people's needs were met.

We found that the registered manager understood the principles of good quality assurance and used these

principles to critically review the home. The registered manager carried out a monthly audit. The registered manager had effective systems in place for monitoring the home, which the registered manager fully implemented. They completed monthly audits of all aspects of the home, such as medicine, care plans, nutrition and health and safety, risk assessments for staff. They used these audits to review the home. Audits routinely identified areas they could be improved upon and the registered manager produced action plans, which clearly detailed what needed to be done and when action had been taken.

There were systems in place to manage and report accidents and incidents. Accident records were kept and audited monthly by the registered manager to look for trends. This enabled the staff to take immediate action to minimise or prevent accidents. These audits were shown to us as part of their quality assurance system. The registered manager said, "We record all incidents and I investigate and also feedback to the provider if need be".

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had been updated by the management team and cross referenced to new regulations.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the home. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.