Burlington Care Limited

The Lawns Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on the 16 May 2017 and was unannounced. This meant that the provider and staff did not know we would be visiting.

The service had not been rated under the new registered provider of Burlington Care Limited so this was a first rated inspection for The Lawns Care Home.

The Lawns Care Home accommodates up to 62 older people, some of whom are living with dementia. There were 56 people living at the home at the time of the inspection.

A registered manager was in post. People, relatives and staff spoke positively about her leadership. A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

We saw issues addressed from an infection control nurses audit inspection on 3 March 2017 were being attended to in relation to a hand washing sink and window ledge on the day of the inspection visit. First thing in the morning we found the first floor bathroom contained clothes and continence products and was untidy. Staff were mainly using this bathroom as one other on this floor was temporarily out of use. We also found two fridges in the dining rooms on both floors contained ice and contained unlabelled food. It was acknowledged and the registered manager took immediate action on the day to rectify the fridges and sent us evidence they had met with night staff to review cleaning rotas and discussed bathroom tidiness.

There were safeguarding procedures in place. Staff knew what action to take if abuse was suspected.

People were safe because risks had been identified and managed. All the staff in the home had completed training to give them the skills and knowledge to carry out their roles and to ensure people in the home were safe.

Systems were in place for the safe storage, administration and disposal of medicines. Records showed people received their medicines as prescribed and in their preferred manner.

People received on-going healthcare support from a range of external healthcare professionals and people's health and nutrition needs were effectively monitored and responded to in line with nationally recognised practice. People were supported to eat a well-balanced diet and those who were at risk of malnutrition and/or dehydration had their food and fluid intake monitored. We found some records in relation to personal care were disorganised and the registered manager addressed this straight away.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

There were sufficient staff deployed and we spoke with the registered manager to ensure staffing levels were reviewed in light of increasing numbers of people. Safe recruitment procedures were followed and staff had completed training in safe working practices and to meet the specific needs of people through face to face training. An effective induction process was in place which was linked to the Care Certificate for all new staff members.

There was an activities co-ordinator employed to help meet the social needs of people. A varied activities programme was in place although people fed back to us they would like more activities

The staff knew the people they were supporting well and treated them in a respectful and friendly way. We saw care plans identified people's needs and wishes although some people we spoke with did not know about their plan of care.

The provider had a range of quality monitoring systems and had made improvements in response to people's feedback and audits. There was a commitment to deliver a good standard of personalised care and continued improvement based on the views of people who used the service and the enhancement of their lives. The staff team spoke positively about the support they received and were motivated and enthusiastic. Complaints, accidents, incidents and safeguarding events were taken seriously, thoroughly investigated and lessons learnt from them.

All staff informed us they were happy working at the service and morale was good. We observed that this positivity was reflected in the care and support which staff provided throughout the day.

The registered provider was meeting the conditions of their registration. They were submitting notifications in line with legal requirements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Actions were required to address issues of infection control concern. These had begun to be addressed on the day of our visit.

There were safeguarding procedures in place. Staff knew what action to take if abuse was suspected.

There was a system in place to manage medicines safely. Safe recruitment procedures were followed.

There were sufficient staff deployed to meet people's needs.

Is the service effective?

Good

The service was effective.

Training was available in safe working practices and to meet the specific needs of people who lived at the home.

Staff followed the principles of the Mental Capacity Act.

People were supported to receive a suitable and nutritious diet and access health care services.

Is the service caring?

Good

The service was caring.

People and relatives told us that staff were caring. We saw positive interactions between people and staff.

People and relatives told us and our own observations confirmed that staff promoted people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Care plans were in place which detailed the individual care and

support to be provided to people.

An activities co-ordinator was employed to help meet people's social needs.

There was a complaints procedure in place. Feedback systems were in place to obtain people's views.

Is the service well-led?

Good

The service was well led.

There was a registered manager in post. People, relatives and staff spoke positively about her.

Effective audits and checks were carried out to monitor the quality of the service.

Staff informed us that they enjoyed working at the home and morale was good.

The Lawns Care 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 16 May 2017 and was unannounced. We visited the service early in the morning following a concern raised with us that people were being got up early in the morning. The inspection team consisted of two inspectors 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 service.

Prior to carrying out the inspection, we reviewed all the information we held about the home. We did not request a provider information return (PIR). A PIR is a form which asks the provider to give some key information about their service, how it is addressing the five questions and what improvements they plan to make.

We contacted Darlington local authority safeguarding and contracts and commissioning teams prior to our inspection. We also contacted Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used their feedback to inform the planning of this inspection.

We spoke with 10 people and three relatives on the day of the inspection. We liaised with a community matron for care homes from the local NHS trust and two General Practitioners who regularly visited the service.

We spoke with the registered manager; deputy manager, senior carer, three care workers, the activities co-ordinator, chef, maintenance man, and two domestic staff on the day of our inspection. We also spoke with four members of the night staff team as we visited early in the morning.

We viewed six people's care records. We also looked at information relating to staff recruitment and training. We examined a variety of records which related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. Comments included, "I'm well looked after, no one can get in. I tell the staff when I'm going out so they know where I am and sometimes stay overnight at a friends." One person who had limited mobility discussed that they were in a ground floor room and when there was a fire drill 'the bedroom door slams shut'. They said this made them feel if there was a fire they would be safe. Other comments included, "Staff check on me regularly" and "Being among people makes me feel safe."

Relatives told us The Lawns was, "Very safe, staff are always popping in," and "I feel happy leaving my relative here." Another person said, "The call bell keeps my relative safe."

We checked the safety and suitability of the premises and equipment. Following a visit by the infection control nursing team from the NHS in March 2017, some areas had been identified as requiring action in the laundry area. It was acknowledged that a timescale of four months had been placed on this requirement. We inspected the laundry room at 7.30am in the morning. We saw there were boxes of clean clothes on the floor. We were told that due to the lift being temporarily out of action the previous day, they were still in situ. At the end of our visit the laundry room floor was clear. During the course of our visit the maintenance staff member was tiling the wall behind the affected sink where the wall was cracked which he told us he had scheduled to undertake. We saw an open topped bin that contained gloves, paper towels and washed red bags from the washing machine that was situated next to the dryer. We sought advice from the infection control nurse team via telephone and they advised to use a foot operated bin with a lid. The registered manager agreed to do this straight away.

At the beginning of our inspection we saw that the first floor bathroom was untidy and cluttered with people's clothes (which we did not know if they were clean or dirty), new continence products and towels. We were told by staff that this was the bathroom mainly used as another bathroom on this floor was out of commission. There was also a smaller bathroom available. We saw fridges in both dining rooms on the ground and first floor one contained ice and one contained food that was not wrapped. The registered manager immediately responded to this when it was raised with them and ensured the fridges were clean and defrosted on the day. Immediately following the inspection they sent us a record of a night staff meeting confirming the issues of keeping bathrooms tidied and a new cleaning rota to ensure these fridges were checked daily had been introduced.

There were safeguarding procedures in place. One of the G.P's who visited the service told us, "I have seen evidence of safeguarding concerns being identified and acted upon appropriately."

Staff were knowledgeable about what action they would take if abuse was suspected. They told us they had no concerns about practices at the service. One staff member told us, "I know how to raise a safeguarding alert, we are all trained to Level One standard and the manager and seniors to Level Two."

We received mixed feedback from people, staff and relatives about whether there was sufficient staff on duty. Four out of the six people we spoke with felt there was enough staff and that they spent one:one time

with them the fifth said, "There could be more". One person said "No, there is not enough staff, I feel sorry for them". Both visitors we spoke with felt there was, "adequate" staff.

One staff member told us, "The staffing levels could be improved at mealtimes and on a morning we could do with more." Another staff member said, "We have the right numbers on paper but people's needs are quite different." Another staff member told us they thought the staffing levels were right. From this feedback, we asked the registered manager and regional director to review the levels of staffing in relation to peak times and people's needs and they stated they would implement a study to analyse staffing levels and deployment.

A staffing tool was used to assess the numbers of staff on duty. This was linked to dependency levels. Throughout our inspection we observed that staff carried out their duties in a calm unhurried manner. Call bells were answered promptly. We concluded that there were sufficient staff deployed to meet people's assessed needs.

Checks were carried out to ensure the building and equipment were safe. Electrical, water and fire checks and tests were carried out. Lifting Operations and Lifting Equipment Regulations (LOLER) checks were carried out on moving and handling equipment. Personal emergency evacuation plans were in place which detailed how people should be supported to leave the building in the event of an emergency.

Staff told us, and records confirmed that the correct recruitment procedures were carried out before they started work. We examined five staff member's recruitment files and noted that a DBS check had been obtained. Written references had been sought as well as ensuring people's right to work and identity was checked and correct. We saw that interview records were maintained and showed the service asked prospective staff members about scenarios related to the roles they were applying for. This demonstrated the provider had systems in place designed to ensure that people's health and welfare needs could be met by staff who were fit, appropriately qualified and of suitable character to do their jobs.

People told us that they received their medicines as prescribed. We found there was a safe system in place for the receipt, storage, administration, recording and disposal of medicines. We did note there were some loose sheets in the medication records that could become lost. The senior carer said they would address this and bring it to the manager's attention straight away.

There were assessments in place where people had been identified as being at risk. They described the actions staff were to take to reduce the possibility of harm. Areas of risk included choking, falls, moving and handling, malnutrition and pressure ulcers. We spoke with one staff member who told us that due to their pregnancy they had been risk assessed by the registered manager and their duties had been changed due to the risks presented in their working area. This showed the service reviewed all risks to all people at the service.

Good

Is the service effective?

Our findings

People and relatives told us that the staff met their needs effectively. Comments included, "Staff are always here for you, the rooms are nice and kept clean and the food is good," and "The home is friendly and everyone is approachable."

Staff we spoke with highly valued the training and told us they felt it was targeted in helping them develop the skills and knowledge they needed to support the people who used the service. A rolling programme of classroom based training was in place and staff were encouraged to access distance learning and development courses. All staff were provided with mandatory training in safe working practices, such as fire safety, moving and handling, and food safety. Training specific to the needs of people living at the home had been undertaken, including dementia awareness, end of life care and the management of actual or potential aggression. One staff member told us, "I am all up to date, the last training I undertook was recording and care planning."

We saw the registered provider had a training officer who carried out induction and other training sessions on a face to face basis with staff which they told us was better than e-learning training they had experienced previously. Induction training was completed to make sure that staff had achieved acceptable levels of competence in their job role. The service delivered the Care Certificate. The Care Certificate is a set of nationally recognised standards to be covered as part of induction training of new care workers.

All staff told us that they felt supported in their roles. Staff told us they had regular supervision. There was an appraisal system in place. Supervision and appraisals are used to review staff performance and identify any training or support requirements.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff were all trained in the principles of the MCA. This meant that people were supported by staff who had a good knowledge and understanding of the MCA and how to apply the principles of the act to people's care and support. People's support plans contained clear information about the level of capacity people had to make their own decisions and where they may need support. The registered manager was proactive in advance planning for people who had capacity at certain times, known as fluctuating capacity. We saw that detailed assessments of people's capacity in relation to specific decisions had been carried out when people's ability to make their own decisions was in doubt.

The registered manager had assessed people who used the service that lacked the capacity to make certain decisions to identify if a DoLS application needed to be made and doing so when it was required. The registered manager was proactive in seeking advice from the granting authority and following up progress on applications that had been made. We saw there were 28 up to date DoLS authorisation in place and these were being supported in line with the directives in the authorisation.

Staff told us that there were good communication systems in place at the service. We reviewed the shift handover records which contained detailed information about people who used this service. We were told by staff that there was always a verbal update given at the start and finish of each shift. These systems helped to make sure that staff had the most up to date information about the changing needs of the people they were supporting.

People's nutritional needs were met. People and relatives were positive about the meals at the service. All except one person were able to eat independently, they were encouraged to eat through verbal prompts for example, "Are you ready for some more sausage and mash." At the start of the meal staff asked people if they wanted to wear a protective cover to put on their clothes, one person refused and this decision was respected by staff.

One relative said, "The food is fine and the portions are big," and another relative stated, "Residents get a choice and I am often offered tea and a scone or cake when I visit on an afternoon". A relative discussed their relative was not eating well so staff had arranged for the community nurse to visit.

People said, "The food is alright", and "Yes, I enjoy my meals, I like the dinners best", another said "I choose to eat in my room, the food is lovely." One person told us they had their own tins of soup and if they don't like the food available, staff warm this for them and serve it with toast at their request.

We found that people's dietary needs were met. Staff members told us, "The food is good. [Name] is a good cook," and "There is always two options on the menu and if they don't want it [Name] will do them something else."

We observed the lunch time period on the ground floor and saw that staff were attentive to people's needs. Individual support was provided discreetly. On the first floor we noted that people had to wait some time from sitting down for their meal to arrive and so people became restless and disengaged. We also noted there was only one staff member present for some of this time and so they could not offer the reassurance needed to everyone. We fed this back to the registered manager and understood there were some technical issues with the food arriving and that other staff were dealing with other people outside the dining room on this occasion. The registered manager told us they would review the dining experience for people on the first floor and implement any changes needed.

People told us that staff contacted health care professionals to meet their specific needs. A visitor discussed with us that the chiropodist came to see their relative every 10 weeks, the relative had been given a manicure from staff, and they also had an appointment with an optician planned.
Records confirmed what people had told us and we saw the registered manager had worked to create relationships with key people from a variety of health support organisations. We spoke with two GP's and they told us that staff were quick to identify any decline or signs of possible decline in people's health. They told us staff were 'responsive' and if anything was requested, such as samples requiring analysis being obtained, this was done promptly.

We saw evidence that staff had worked with various agencies and accessed other services when people's

needs had changed, for example, consultants, GP's, district nurses, speech and language therapist, dietitians, the chiropodist and dentist. This demonstrated that the expertise of appropriate professional colleagues was available to ensure that the individual needs of people were being met to maintain their health.

Good

Is the service caring?

Our findings

People and relatives told us that staff were caring. People felt they received good care and the staff knew their likes and dislikes. One stated, "The staff know by looking at me if I need help, I don't have to ask." Comments about staff care included, "Good", "Fine", "Sometimes I do feel rushed when getting dressed", "Carers are very nice, they have a laugh with me", "'m quite impressed, the previous home wasn't as good as this. It's well run and the staff are good", "There lovely (care staff) I get good care and my daughter thinks so too".

Staff were motivated and committed and spoke with pride about the importance of ensuring people's needs were held in the forefront of everything they did. Comments included, "I love caring for people and knowing I've made a difference to them is the best," and "I have been here 13 years, I love the residents, the home and the staff." One visitor noted staff were aware of their relatives needs as, "When we first arrived they discussed what time she likes to get up, time she likes to eat and if she liked a bath or shower".

We observed people were comfortable in the company of staff and responded well when engaging with them. There was a calm, relaxed atmosphere and we saw the staff were kind, friendly and respectful. It was evident there were good relationships. During our visit we observed the staff were caring in the ways they treated people. They spoke politely, adjusting how they communicated with each person, and listened to what they had to say. There were high levels of interaction balanced with giving people space to spend their time as they wished.

We observed that staff were mindful of people's privacy, always knocked on doors and waited for answer before entering the room. Staff described their ways of ensuring privacy and providing dignified care. People told us, "Staff knock on my door before they come in," and "If they want to talk about something private they make sure no one can hear". We saw staff using people's preferred names and knocking before entering rooms. We also saw one staff member discretely asking a person if they wanted help to change their top which had become stained during the mealtime. This showed staff helped support people to maintain their dignity.

All staff were trained in the values of person-centred care, with an emphasis on caring for people as individuals with diverse needs. The registered manager said this training encompassed care planning, promoting privacy, dignity and independence and following people's preferences and wishes. One person told us, "I have made friends, I have a large room and have been able to personalise it."

One visitor discussed how staff encouraged independence by encouraging their relative to use their walking frame, "This keeps her going and gets her out of the chair". When asked about promoting independence all those we spoke with felt they were encouraged with one person commenting, " The staff get me to go to the dining room to eat instead of staying in my room and I know it's good for me to keep getting about." People were supported to maintain their independence. One staff member told us, "I offer people the chance to do what they can for themselves such as washing their own face."

Care plans contained information about people's life histories which had been developed with people and their relatives. This meant that information was available to give staff an insight into people's needs, preferences, likes, dislikes and interests, to enable them to better respond to the person's needs and enhance their enjoyment of life.

Some people we spoke with were not always aware of their care plan when we spoke with them. We raised this with the registered manager who stated they would ask senior staff and the activity co-ordinator to work on this with everyone using the service.

The two relatives we spoke with said they were encouraged to visit home at any time of day or night. One relative told us they visited every day and were always welcomed and offered a drink. The relative discussed the 'protected mealtimes' however stated they were welcomed to visit and assist their relative to eat.

We saw how people's end of life wishes were met by the home. Staff at the service had been trained in supporting end of life care. The registered manager told us that people coming to the end of their life would be supported for as long as possible to remain at The Lawns, with help from GPs, community and specialist nursing services.

At the time of our inspection one person accessed the services of an advocate, and we saw more informal means of advocacy through regular contact with families. This meant that people were invited to be supported by those who knew them best. Advocates help to represent the views and wishes of people who are not able to express their wishes.

Good

Is the service responsive?

Our findings

People and relatives told us that staff were responsive to people's needs. One relative told us, "It's reassuring my relative is safe, and well cared for, the staff are responsive." One person said, "Staff keep people independent as much as possible."

We spoke with two GPs who visited the service regularly. They told us the staff team and especially the deputy manager were knowledgeable about people's needs and they had absolutely no concerns about the standard of care and responsiveness of the service.

Preadmission assessments were carried out.
We looked at six care plans belonging to people who used the service. These records showed that people had their needs assessed before they moved into The Lawns. This ensured the service was able to meet the needs of people they were planning to admit to the service.

We found that risk assessments were in place, as identified through the assessment and care planning process, which meant that risks had been identified and minimised to keep people safe. These included measures to be taken to reduce the risk of falls whilst encouraging people to walk independently, measures to reduce the risk of pressure ulcers developing or to ensure people were eating and drinking. Standard supporting tools such as the Waterlow Pressure Ulcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments.

A personal care plan for people's individual daily needs such as mobility, personal hygiene, nutrition and health needs was written using the results of the risk assessment; which detailed the care needs, support, actions and responsibilities staff were to take to reduce the possibility of harm. We saw that these were regularly reviewed to ensure people's needs were met and relevant changes added to individual care plans. We saw daily notes were kept for each person, they were concise and information was recorded regarding basic care, hygiene, continence, mobility, nutrition, activities and interests. This meant that people were appropriately cared for and supported as records were complete.

People's care records were personalised to reflect their individual preferences, support and what they could manage for themselves. The care planning system was found to be easy to follow, with risk assessments and care plans and evaluations. There was information about people's life history, such as key events in their life, work history, spirituality, hobbies and interests.

We saw care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' decisions and we saw that the correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form. Emergency Health Care Plans (EHCP) were in place in care plans we looked at. An EHCP is a document that is planned and completed in collaboration with people and their GP to anticipate any emergency health problems. We saw end of life care plan for people where a person had

clearly detailed their wishes and requests. needed. This meant that information was available to inform staff of the person's wishes at this important time to ensure that their final wishes could be met and staff were supported with the process.

There was an activities coordinator employed to meet people's social needs. People and relatives spoke positively about her. We spoke with the activities facilitator who told us that she carried out group activities as well as one to one activities.

On the morning of the visit an outside clothing agency was visiting to allow people to shop. People from both floors were encouraged to access the clothing displays. People discussed activities on offer were singers / performers, outings (which have to be paid for additionally), colouring, armchair exercise and music and singing. One person said "I went for to the park recently, it was beautiful, and I loved it," another person described the singers as, "Out of this world". All the people and visitors to The Lawns felt there could be more activities especially more music, singers and outings.

None of the people we spoke with who lived in The Lawns felt they had a reason to complain however all felt they knew the process of how to complain and spoke about speaking to a senior or the registered manager. There was a complaints procedure in place. We saw that complaints had been acted upon by the registered manager using well documented records and any learning or actions required from complaints was carried out and shared with the staff team.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. People, relatives and staff spoke positively about them.
One visitor described the registered manager as, "Very approachable." One of the local GP's told us, I have previously raised issues with [Name] the manager and these have been dealt with." One person described the atmosphere as, "Warm and welcoming." One staff member told us, "[Name] has come and worked really hard with staff to build standards up. If there is ever a problem, she will sort it."

We observed the registered manager to have a very hands on approach in the home, dealing with visitors, staff, and residents. We witnessed the manager having knowledge of individuals and responding to their needs. For example when a person asked for a drink this was provided. The registered manager told us they had written to people's relatives to introduce themselves and to explain who they were and that they were happy to meet with people to discuss any issues.

Staff we spoke with told us they were happy in their role and felt supported by the management team. People told us they were happy with the service. One staff member told us, "She listens to the staff and is approachable."

Staff were regularly consulted and kept up to date with information about the service and the registered provider. Staff meetings took place regularly and we saw that minutes of meeting were available for all staff members to read. We saw staff were given updates about the service and were encouraged to share their views.

The home carried out a range of audits as part of its quality programme. The registered manager explained how they routinely carried out audits that covered the environment, health and safety, care plans, and medicines as well as how the home was managed. We saw clear action plans had been developed following the audits, which showed how and when the identified areas for improvement would be tackled. This showed the home had a monitored programme of quality assurance in place. The regional manager also visited the service regularly and carried out a monthly monitoring visit. We saw they got feedback from people and staff as well as checking complaints, safeguarding, the premises and registered manager's audits. We saw that where issues had been raised that the registered manager had responded, for example, there had been concerns over staffing at night-time. The manager and senior team had carried out 11 visits since December 2016 to monitor and speak with night staff and the night staff members we spoke with said they had felt supported by these visits.

We saw that surveys were sent out twice yearly and analysed by the service and the results and comments displayed for people to read in the reception area.

This demonstrated that the registered provider gathered information about the quality of their service from a variety of sources.

People who used the service accessed local shops and leisure facilities. We saw the service was working closely with healthcare professionals and the registered manager told us about how the service was involved in the local community with local schools and churches.

We saw that records were kept securely and could be located when needed.

The registered provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.