R & E Kitchen

Lavender House Care Home

Inspection report

166 Newtown Road
Southampton
Hampshire
SO19 9HR

Tel: 02380444234
Website: www.lavenderhouse.org.uk

Date of inspection visit:
10 December 2015
15 December 2015

Date of publication:
24 March 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 and 15 December 2015 and was unannounced.

Lavender House Care Home offers accommodation and care for up to 20 people who may have dementia. The home is over two floors and the second floor is accessed using a stair lift. There were 16 people living at the home when we visited.

There was not a registered manager in place. 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. The previous registered manager de-registered in September 2015.

The provider did not ensure people were protected through safe recruitment procedures. There were safe medication administration systems in place so that people received their medicines when required, however, some recording was not accurate.

People were being supported by staff who had did not have the opportunity to maintain their skills and knowledge. Staff did not have full access to formal induction, refresher training, formal supervision or appraisal of their work.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. This legislation protects people's rights and freedoms. We found the manager was meeting the requirements of the Deprivation of Liberty Safeguards. An application had been made to the local authority for the majority of people living in the home and they were waiting for the outcome. However, there was a lack of training regarding the Mental Capacity Act 2005 which had led to a particular situation being misunderstood.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting concerns. Staff had been trained in safeguarding adults and were aware what procedures to follow if there was a suspicion of abuse. Risks to people's personal safety had been assessed and plans were in place to minimise these risks.

People were supported to have a meal of their choice by organised and attentive staff. If they became unwell staff made a referral to their GP or other health care professionals as appropriate.

People appeared happy and contented and were treated with kindness and compassion in their day-to-day care. There was a relaxed atmosphere in the home. People were supported to be actively involved in making

decisions in their daily lives, such as what clothes to wear. People's privacy and dignity was respected by staff.

People's needs were assessed before they moved into the home to ensure staff could meet their needs. Care plans were personalised and each file contained information about the person's likes, dislikes and people important to them.

The provider had a complaints procedure in place which was displayed by both entrance doors and complaints were investigated.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home, although people and their relatives did not have formal opportunities to feed back their views about the home and quality of the service they received. The manager had notified CQC about significant events.

We identified breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

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 is not always safe.

The provider did not ensure people were protected through safe recruitment procedures.

Whilst records were completed to show who received their medicines and when, some other recording around medicines was not accurate.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting concerns. People were supported by adequate numbers of staff.

Is the service effective?

Requires Improvement

The service is not always effective.

People were being supported by staff who did not have the opportunity to formally discuss their performance or update their training regularly.

There was an understanding of how the Deprivation of Liberty Safeguards applied to people living at the service but a lack of understanding regarding best interest decision making processes.

People were supported to eat meals they enjoyed.

Staff responded appropriately if people became unwell.

Is the service caring?

Good

The service is caring.

People appeared happy and contented and were treated with kindness and compassion in their day-to-day care.

People were supported to be actively involved in making decisions in their daily lives, such as what clothes to wear.

Staff respected people's privacy and dignity.

Is the service responsive?

Good

The service is responsive.

People's needs were assessed before they moved into the home to ensure staff could meet their needs.

People had care plans in place and received the care and support as detailed in the plans.

The provider had a complaints procedure in place.

Is the service well-led?

Requires Improvement

The service is not always well led.

There was not a registered manager in place but the manager had started the process to be registered.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home but there was not an effective system to seek the views of people living at the home.

The service had a positive culture that was person-centred.

Lavender House 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.

This inspection took place on 10 and 15 December 2015 and was unannounced.

The inspection was carried out by one Inspector. Before the inspection, we reviewed the information we held about the service. This included previous inspection reports and notifications about important events which the service has to send us by law. We also spoke with a representative of the local authority as they had recently visited the home as part of the quality assurance process.

During the inspection we spoke with two people, five visitors, three staff, the manager and a visiting health care professional. We observed the lunchtime meal and spent time sitting with people in the communal areas. We looked at a range of records including two care plans, four staff recruitment files and records of audits.

Requires Improvement

Is the service safe?

Our findings

The provider did not ensure people were protected through safe recruitment procedures. The provider had a written policy in place which stated that job offers would depend on "satisfactory clearance" of Disclosure and Barring Service (DBS) checks and a minimum of two references. However, we looked at the recruitment files for the four newest staff and found two did not have a DBS check in place and a further two had been received after the staff members started work at the home. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The files also showed that one staff member had two references but the other three had one reference in place which meant the provider's policy was not followed. Therefore, the provider could not be assured that people were protected from being supported by staff who may be unsuitable to work at the home.

The failure to ensure DBS checks were in place before allowing staff to work in the home was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to keep accurate records regarding medicines which are brought into the home. Whilst records were completed to show who received their medicines and when, we found some other recording was not accurate. For two people we saw they each had a box of tablets which had not been recorded when they were brought into the home. One of these was a type of medicine which needed extra recording to meet legal requirements. The lack of recording meant staff would not be able to see easily if any were missing. There was a box of tablets without a dispensing label. Staff thought they belonged to a particular person but this could not be evidenced through the medication administration record as the relevant page had been lost.

The failure to ensure a robust audit trail for prescribed medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received their medicines when required. Care plans included detailed instructions for staff about how to administer medicines, such as asking people if they were ready and advising of each step as they went through the administration process, whilst respecting their dignity. Medicines were stored safely.

People were supported to take their medicines by trained staff which included the deputy manager, two senior and four care staff. Training consisted of a day's learning, followed up by an online assessment and three competency tests, all of which had to be passed before staff were considered safe to administer medicines. If staff were to make an error when administering medicines, they would undertake the competency tests again, to refresh their knowledge.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting concerns. Staff had been trained in safeguarding adults and were aware what procedures to follow if there was a suspicion of abuse. They were also aware of whistle blowing procedures and what they were used for. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or

directly to external organisations. The manager had made referrals to the safeguarding team when necessary, such as when a person's stay in hospital had resulted in a pressure area developing.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Examples of this included supporting people to walk around the home or to go out with relatives. The manager said risk assessments were undertaken on a daily basis, for example, if someone was looking "a bit shaky", staff would walk with them whereas the person may usually walk independently. Equipment such as bed rails or a hoist would only be used if a risk assessment identified that this was the best way to support a person's needs. Staff said if people's abilities changed they passed the information on to a senior staff member who then updated the care plan. People had personal emergency evacuation plans in place which were kept in a "grab pack" which staff could access easily in an emergency.

The manager said staffing levels were decided by the provider and were set at three staff during the day and two at night. Staff worked extra shifts or agency staff were employed to ensure these staffing levels were met. Staffing levels were considered when assessing people's needs before they moved into the home. The manager was clear that if the staffing levels meant people's needs could not be met, they would not offer them a room.

We observed staff responding to people's needs in a timely way and they appeared calm and not rushed. When staff were asked if they felt there were enough staff on duty, comments included "Most of the time" and "It is ok at moment, but we will need more with a full house" but they agreed people's needs were met.

Requires Improvement

Is the service effective?

Our findings

People were being supported by staff who had did not have the opportunity to maintain their skills and knowledge. Staff did not have full access to formal induction, up to date training, supervision or appraisal of their work. The provider considered essential training to include moving and handling, use of the hoist, fire safety, health and safety, infection control and safeguarding and required that this training be undertaken again at regular intervals. However, nine staff were not up to date with first aid, six were not up to date with food safety and seven were not up to date with health and safety. Ten staff were overdue for the annual moving and handling refresher by three to four months. It was not known whether staff had completed infection control training. However, the two staff we discussed training with were positive about the training provided. One said "We are given dates and we go along, we get quite a bit during the year. It is good, you do forget things if you are not using, the trainers make it interesting. You can request training and [senior staff] ask you if you'd like to do something." Another staff member said there was "good training, they tell you what you need to know, get refresher every year so you remember everything." Records showed that all staff had completed a course in dementia awareness and we saw them responding to people appropriately.

New staff undertook an induction process which included the manager showing them around the home, going through the policies and procedures and arranging some "shadow" shifts which meant new staff worked with experienced staff. However, new staff had not had the opportunity to undertake the Skills for Care induction (previously the industry standards) but the manager said that staff would be able to work towards the new Care Certificate in the future.

Staff did not receive formal supervision or appraisal to support them in their roles. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. The provider's policies stated that staff should have supervision every six weeks as well as a formal review of their job performance every six months, (or annually as stated in a different policy). However, the manager said "It is an open door policy here, I do informal supervision all the time, asking [staff] how they're doing, how they're getting on."

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. Nine people had recently been given a vaccination against influenza. The manager had been contacted by a health care professional who had said that they needed letters of consent signed by people's next of kin, by a certain date. The manager therefore undertook this process and the vaccinations were given. However, next of kin cannot legally give consent unless they have been awarded specific legal powers to include health care. Therefore, whilst the manager consulted people's relatives and the outcome was likely to be the same, the process should have followed a different format and been recorded as a best interests decision.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found the manager was meeting the requirements of the Deprivation of Liberty Safeguards. An application had been made to the local authority for the majority of people living in the home and they were waiting for the outcome.

People were supported to have a meal of their choice by organised and attentive staff. Staff told us they found it beneficial to move the dining tables around in different ways. During our inspection they were placed in one row, with seating each side. Staff said they found people responded positively to this and ate "better". Staff also said people liked it if they sat with them to eat their own meals. We observed a relaxed atmosphere at lunch time. Two staff members were sat next to people, supporting them to eat their meal. Some people wore aprons to protect their clothing, some had their food served in bowls with spoons so they were then able to eat independently. If people did not want to eat the main meal they were offered other choices. We heard a staff member persevering with offering a person several different choices for dessert. The manager told us they had made four different meals for one person in an effort to encourage them to eat. Staff also noticed when people had left the table, for example between courses, and encouraged them back to continue eating. People were offered a choice of drinks, as well as more than one drink after lunch.

People's dietary needs and preferences were documented and known by the chef and care staff. A relative said "Staff bring drinks round all day." One person's care plan showed they did not like to eat meat on Fridays and the records showed they ate fish. The chef spoke with people to gain their views about the food. People were provided with food which met their needs, for example, a diabetic diet or soft food. Food was fortified for most people through the use of ingredients such as cream and butter, unless dietary requirements contra-indicated this. The manager told us how staff had noticed one person was not swallowing well so they requested a visit from the Speech and Language Therapist. Staff recorded what people ate and drank so they could monitor their food and fluid intake.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. A relative said "The GP was called out for a chest infection…they phone us if [relative] is not well." They also confirmed that the GP reviewed prescribed medicines regularly and an optician had visited to undertake an eye test.

During our visit we saw a district nurse was visiting because staff had asked them to look at the skin of one person as they were concerned about how it looked. The district nurse said they visited twice a week when necessary. Staff noticed when people appeared to have a deterioration in their mental health and spoke with the GP regarding a referral to the mental health team.

Good

Is the service caring?

Our findings

People appeared happy and contented. One person said they were "happy" and another said, "Staff do treat me well." A visitor said their relative "seems happy enough, they look well." We were also told how a person had been able to bring a personal item into the home, which staff looked after and maintained. This showed that staff understood and respected the person's attachment to the item.

People were treated with kindness and compassion in their day-to-day care. There was a relaxed atmosphere in the home. When we sat in the lounge, on more than one occasion, we saw people got up and started to dance or sing. Staff responded by joining them which meant people had a positive interaction. Staff told us they often did this as people responded well.

Staff spoke about how they developed positive caring relationships with people. One said "We are friendly, we sit down and chat to them, play games, interact and get to know different things they like to talk about." Another said "We include everyone in everything and make sure they're all aware of what's on [in the home]." The manager told us how staff had showed they cared about a person who had become unwell, by spending time with them when they had finished their shift.

Staff attended "handover" meetings which were used to pass over information between the staff on different shifts. We observed one of these meetings and heard staff talking about people with compassion. One staff member asked if a person was better now, as they had looked pale when they last saw them and another staff member noted that one person had a cough and cold. Staff spoke about another person who had recently been choosing to stay in their bedroom and how they were taking food and drinks upstairs to them, respecting their decision.

People were supported to be actively involved in making decisions in their daily lives, such as what clothes to wear. Staff said "We ask them, or put things in front of them so they can choose." The manager described the ethos around how staff supported people. There was a "summary of care" form in place so staff would know how people liked things to be done. The manager told us "Staff ask people if they'd like a bath, or to use the toilet. I go out [on the floor] every day, I see people, see the interactions". People chose when to go to bed and when to get up. If people did not want their food at the usual meal time it was kept and offered to them later.

People's privacy and dignity was respected by staff. One relative said "Staff are welcoming, they offer you tea, they leave us alone to visit." They also described an incident which had occurred when they took their relative out and they needed staff support when they returned. They said, "Staff assisted, things don't feel like too much trouble."

Staff explained how they ensured people's dignity was maintained when they were supporting them with personal care. This included making sure the door was closed and covering people with a towel. One staff member said they knocked bedroom doors and asked people "if they want us to come in and I ask if they want to get up, I ask if we can help." We heard a person ask staff to go to the bathroom and although staff

were busy writing records, they stopped straight away and supported the person to the toilet bathroom, at the same time assuring them they would make them comfortable. One staff member was the nominated dignity champion and they had received training in this.

Good

Is the service responsive?

Our findings

A visitor to the home said "It is nice and calm, people are up and dressed. People are happy and staff do a good job." We found people's needs were assessed before they moved into the home to ensure staff could meet their needs. Staff involved people and their relatives, if appropriate, in assessment and planning care. Care plans were personalised and each file contained information about the person's likes, dislikes and people important to them. Plans clearly explained how people would like to be supported and included specific, individual information. One person sometimes had hallucinations and the care plan had strategies in place for staff to follow. Staff were aware of, and adhered to the care plan. Another example of staff meeting people's needs was a care plan which said the person felt the cold and liked a blanket. Staff knew this and we saw the person did have a blanket on their knees.

The manager was responsive to people's changing needs. We spoke with a district nurse who said they had recommended that to meet one person's needs, they should be offered a ground floor bedroom. The manager responded to this and the person moved downstairs. The manager sought professional advice in response to people's individual needs. For example, one health care professional had suggested that some people found it easier to locate and use the toilet if it had a blue seat. The manager had followed this advice for a particular person and found there had been an improvement.

A relative told us there were activities available and their relative was "happy to join in. There are photos on the pin board of recent events and the photos do get changed." They mentioned they had seen the "pub night" the previous evening. The lounge had been transformed into the Lavender Lion Public House for the evening to give people a sense of being in a pub. A sign had been made, alcohol and snacks were served and a quiz was held. Other activities included exercises and movie afternoons, where the curtains closed and popcorn was provided.

The provider had a complaints procedure in place which was displayed by both the doors into the home. Relatives told us they would be able to complain and that everything they had discussed had been addressed. One said they would talk to the manager first, then complain if necessary. Staff knew how people could complain and what to do if someone complained directly to them. There had been one complaint in 2015 which had been investigated and a letter of apology sent. Staff had been sent a memo to remind them of the procedures to follow, regarding the particular issue.

Requires Improvement

Is the service well-led?

Our findings

There was not a registered manager in place. 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. The new manager had been in post since June 2015.

One relative said the manager had "made positive changes" in the home. A staff member said the manager was "getting things done, she's all for the residents and making things work properly."

The manager had been supported by their line manager in the home for the first three months and they continued to visit regularly. The manager could contact managers of other homes within the group and had spent a day shadowing one of them.

People and their relatives did not have formal opportunities to feed back their views about the home and quality of the service they received. For example, people, their relatives and staff had not been given the opportunity to complete a survey and meetings were not arranged to seek the views of people living in the home. The manager said they did spend time sitting with people discussing "things about the home." However, this is an area for improvement as the provider should ensure people have a range of opportunities to give feedback and shape the service being provided.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. The manager undertook a range of audits to monitor the quality of care and support that people received. Audits included looking at accidents, medicines, the cleanliness of the kitchen and home and maintenance of the environment. The manager had responded to issues of concern which had been identified. Examples included changing the procedure for looking after people's money to improve security and fitting a self-closing door to the laundry as the fire safety officer recommended. The local authority quality assurance team had visited the home and made some suggestions for improving the service. The manager had taken action to address these.

The manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

Staff felt the culture of the home was open, honest and transparent. One said "The manager is very approachable, there is a good atmosphere. I come to work, laugh, joke and do the work. It is the resident's home and we always include them in what we're talking about." Another echoed this, saying "Residents can do what they like, everyone is friendly, everyone will do whatever they can for a resident. Staff always work together as a team."

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 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of a robust audit trail for prescribed medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed There was a lack of a robust recruitment procedure to ensure people were supported by staff who were safe to do so.