Lavender House Care Home LLP

Lavender House Care Home

Inspection report

205 Broadway
Peterborough
Cambridgeshire
PE1 4DS

Tel: 01733562328

Date of inspection visit:
30 November 2016

Date of publication:
16 December 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Lavender House Care Home is registered to provide accommodation and personal care for up to 36 people. People living at the home have physical needs and some of the people live with dementia. The home is situated close to the city of Peterborough. Short and long stays are offered. At the time of our inspection there were 33 people living at the home.

This comprehensive inspection took place on 30 November 2016 and was unannounced.

The provider is required to have a registered manager as one of their conditions of registration.
A registered manager was in post at the time of the inspection. A registered manager is a person who has registered with the CQC to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the service. People were supported to take their medicines as prescribed.

People were helped to eat and drink sufficient amounts of food and drink. They were provided also with choices of food and drink to meet their individual dietary preferences and requirements. People were supported to access health care services. This was to ensure that their individual health needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was aware of what they were required to do should any person lack mental capacity. DoLS applications had been made and conditions of those authorised were being met. People were able to make decisions about their day-to-day care. Staff were trained and had knowledge about the application of the MCA.

People were looked after by staff who were trained and supported to do their job.

People were looked after by kind staff who treated them with respect and dignity. They and their relatives were given opportunities to be involved in the review of people's individual care plans.

Care was provided based on people's individual needs. Staff had access to up-to-date care plan guidance to ensure that people's needs were met in accordance to their assessed needs. There was a process in place so that people's concerns and complaints were listened to and action was taken to address them.

The registered manager was supported by representatives of the provider, ancillary staff and a team of care staff. Staff were supported and managed to look after people in a safe way. Staff, people and their relatives

were able to make suggestions and actions were taken as a result. Quality monitoring procedures were in place and action was taken where improvements were identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's individual needs were met by sufficient numbers of staff.

People were kept safe as there were recruitment systems in place which ensured they were looked after by suitable staff.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

The provider was acting in accordance with the Mental Capacity Act 2005 legislation to protect people's rights.

Staff were trained and supported to enable them to meet people's individual needs.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by kind and attentive staff.

People's rights to independence, privacy and dignity were valued and respected.

People were involved and included in making decisions about what they wanted and liked to do.

Is the service responsive?

Good

The service was responsive.

People's individual health and social care needs were met.

People's needs were kept under review to ensure their planned

care was appropriate to their needs.

The provider had a complaints procedure in place which enabled people and their relatives to raise their concerns. These were responded to, generally to the satisfaction of the complainant.

Is the service well-led?

Good

The service was well-led.

People were enabled to make suggestions to improve the quality of their care.

Management systems were in place to ensure that staff were aware of their roles and responsibilities in providing people with the care that they needed.

Quality assurance systems were in place which continually reviewed the quality and safety of people's care.

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 comprehensive inspection took place on 30 November 2016 and was unannounced. It was carried out by one inspector.

Prior to the inspection we made contact with a local authority monitoring officer. We also had information provided by a member of the local health watch. This was to help with the planning of the inspection and to gain their views about the management of the home.

During the inspection we spoke with two directors of the registered provider; the compliance and quality and education manager, and the registered manager (referred collectively as the SMT (the senior management team) for the purpose of this report.) We also spoke with the chef and their kitchen assistant; one senior member of care staff; one member of care staff; an agency member of care staff and one laundry assistant. In addition to this we spoke with a visiting hairdresser; one visitor and six people who were living at the home.

We looked at three people's care records and medicines' administration records. We also looked at records in relation to the management of staff and management of the service, including audits and minutes of meetings. We observed how people were being looked after.

Good

Is the service safe?

Our findings

We found that people were kept safe from the risk of harm. People told us that they felt safe because staff were kind and caring. Both of the visiting hairdresser and local authority contracts monitoring officer told us that they had no concerns about how people were being looked after.

Staff were trained and aware of their roles and responsibilities in keeping people safe from harm. They demonstrated their knowledge of the training that they had attended. This knowledge included knowing the different types of harm, such as physical, psychological or financial. They were able to tell us what signs and symptoms people might have in the event that they were being harmed. One member of care staff said, "They [person] may lose their appetite. Or if there is any bruising. Or a change of mood." Staff were aware of the correct reporting procedures in the event they suspected or witnessed people being harmed. This included reporting their concerns to the registered manager or to the appropriate external authorities.

Recruitment processes were in place to ensure that only suitable staff worked at the home. One member of care staff described their recruitment. They said, "I had a DBS [Disclosure and Barring Scheme police check]. Two references from my previous employers. I came in for an interview [before working]. There was an application form. I didn't start the job until my DBS and references came back." The compliance and quality and education manager told us that they had taken part in the recruitment of job applicants. They confirmed that the required checks were made before job candidates were employed.

People were kept as safe as possible due to the assessment and management of their risks. Risks included, for example, those associated with falls, inadequate nutrition and development of pressure ulcers. Measures were in place to minimise the level of assessed risks. The registered manager gave an example of the actions that had been taken in respect of one person who was at a high risk of falling. They said, "They [name of person] has a sensor mat [to alert staff of when they are getting out of bed]. They have a lowered bed and are observed closely. The falls [prevention team] have been involved." We saw how staff members closely monitored the person to keep them safe as far as possible. The chef told us that there was "excellent" communication between the care and catering staff teams. This had enabled them to provide additional and fortified food and nutritional supplements for those people who were at risk of inadequate nutrition. Equipment was provided for people who were at risk of pressure ulcer development. One person told us that they had recently developed a superficial sore area. However, due to the provision of pressure-relieving equipment and care, their skin was now intact.

People were looked after by sufficient numbers of staff to meet their individual needs. People told us that there was always enough staff to look after them. Members of staff also told us the same. The registered manager said that in the event of unplanned absences, such as staff sickness, this was covered by other staff members who were willing to work extra hours. Agency staff were only used to supplement the permanent team of staff. One agency member of care staff told us that they were responsible in providing one-to-one care, most week-day mornings. They added that they had done this since September 2016. This frequency of working at the home had enabled them to provide the person with the care in a consistent way.

We saw members of care staff had the time to sit and talk to people. One person, who was at a high risk of falls, was closely observed. People's call bells were answered within less than two minutes. The lunch time was calm because there were sufficient staff members to support people with their food and drink. Furthermore, we saw staff quickly respond to an emergency situation, which was satisfactorily dealt with.

We found that people's medicines were safely managed. People said that they were satisfied with how they were helped to take their prescribed medicines. One person said, "I get them [medicines] morning, lunchtime and at night." Another person said, "I am a diabetic and I get tablets for that." A third person said, "I have to have eye drops. They [staff] are very good at doing that." People said that they had their prescribed medicines when they needed them. This included, for instance, regular pain relief. People's medicines administration records [MARs] showed that people were given their medicines as prescribed.

Medicines were administered by staff who were trained and assessed to be competent to do so. The senior member of care staff said that they had their medicines administration practice observed by the registered manager "only about a week or two ago." Records showed that staff had attended training and were assessed to be competent in the management of people's prescribed medicines. We saw that people were given time to take their medicines safely and the MARs were checked before people had their medicines and signed after they had taken them. Medicines were stored securely so that no unauthorised person had access to these. However, during the lunchtime medicines round we saw on two occasions that medicines were not kept securely. We saw medicines were left on top of the unattended medicines trolley. We saw that there was no person walking about in the vicinity of the unattended medicines trolley. However, we brought this potential risk to the attention of the SMT.

Good

Is the service effective?

Our findings

We checked to find out if people were being looked after in a way that protected their rights. We found that the provider was ensuring that people's rights were respected in line with the Mental Capacity Act 2005 [MCA]. The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in registered services are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that conditions in people's authorised DoLS were being adhered to. This was to ensure that any imposed restrictions, such as constant supervision and inability to leave the premises, were lawful. Staff were trained in the application of the MCA and had some understanding of this piece of legislation. One member of care staff spoke about the assessment process of people's mental capacity. They said, "The person's GP, a relative and social worker would be part of this." Decisions were made by, or on behalf of the person regarding their treatment in the event of a life-threatening incident. This included decisions, in relation to resuscitation, made by a medical practitioner in consultation with the person or their legal representative.

We found people were being looked after by staff who were trained to do their job. The local Healthwatch team reported that people had told them that they had confidence that staff were trained and competent to know how to do their job. Additional information provided by the local Healthwatch team told us that staff attended training to do their job, which they enjoyed.

Members of care staff told us that they had attended a range of training. Training records showed that staff had attended training in a range of subjects which included dementia awareness and diabetes. One member of care staff told us how they benefitted from their dementia care training. They said, "One thing that sticks with me is the choice you give with people with dementia. Such as a choice of food. They may have previously been a vegetarian but now wanting to eat meat. You have to adapt to the person's change of state of mind." The chef told us that, following their recent training, they had an understanding of how dementia might affect people's appetite. They said that the people with dementia, who were currently living at the home, had no issues with eating their food. However, they were mindful of ways to prepare food, based on their training, should this change. They said, "Tastes can change with people who have dementia. Or we can try people with their food later. And having food with more colour. If food is more 'vibrant' it stimulates part of the person's brain [in wanting to eat.]" They added that their refresher training was useful in managing people's diabetes by means of nutrition. They told us how they prepared foods for people with diabetes and showed us the different food substances which contained reduced sugar.

Members of staff said that they felt supported by members of the SMT and by each other. One member of the catering staff said, "The owners are very good and listen to you. If you have any problems you can go and have a chat with them." One member of care staff and one member of the laundry staff both said that different teams worked well to support each other. The member of laundry staff said, "It's like a home here. We work as a team." One member of care staff said, "I get on well with the staff. There is very good team work."

One of the directors described the method of supervising staff. This included checking and testing staff's knowledge of their training. They said, "We theme our supervisions. The last one was done on safeguarding; infection control and MCA knowledge test." Appraisals were carried out on an annual basis to review the staff members' job performance. Supervised practice was also provided on a less formal basis. This included competency assessments of staff when managing people's prescribed medicines. During lunch time we saw a senior member of care staff supervise a member of care staff. This was to ensure that they sat down next to the person, rather than stand over them, when they were encouraging them to eat their meal.

We found that people's choices in relation to eating were valued. People told us that they were able to eat their meals in their room and that this was their choice. One person said, "I prefer having my breakfast being brought to me. First thing in the morning I have a pot of tea and cornflakes and that is just fine." Another person said that they preferred to eat their meals in the quiet of their room. Other people had chosen to eat their lunch in the communal dining room. Choices of menus were presented in large print and photographic format and were on individual tables. The registered manager told us that for people who chose to eat in their room, they were provided "every Monday" with the weekly menu. Alternative options were available. The chef gave an example of these. They told us that, on the day of our visit, five people were having chicken instead of beef and one person was having chicken soup rather than the leek soup. People told us that they were offered choices and we saw one person having a sandwich for their lunch, as they had requested, instead of the main menu lunch option. For tea time options were also available. The catering assistant said, "Sometimes people will ask for boiled or scrambled eggs." One person said, "They [staff] give you anything you want [to eat.]"

People's dietary and nutritional needs and preferences were met. Members of care staff were aware of people's individual dietary needs and preferred portion sizes when they were serving up people's meals. People told us that they always had enough to eat and drink. We saw that they had cold drinks placed within their reach so that they could take these independently. We saw that people were offered hot drinks mid-morning and in the afternoon. The chef told us that they prepared food according to people's dietary needs. Information about these included soft diets and diets for people with diabetes. Nutritional supplements were available for people with unintentional weight loss. These included home-made supplements; milk shakes made following a community dietician's advice and fortified foods. The chef said, "We use a lot of cream here." People's weights were recorded and these showed that people's weights were stable due to the effectiveness of how their individual nutritional needs were being met.

We found that people's individual health needs were met. People told us that the staff had helped them access health care services and had been seen by GPs and district nurses. One person described how satisfied with how the district nurse had treated their hearing difficulty. They said, "The district nurses syringed my ears and my hearing is a lot better." Another person told us that they had been seen by the district nurse and that care staff had followed their advice. They told us that they felt more comfortable as their skin was "now healed." A third person said, "The GP comes when you need." Care records showed that people had been seen by GPs. This included, for instance, a change in a person's breathing or an onset of pain. People had access to other health care employees, which included eye checks and a speech and language therapist [SALT.] The chef told us that SALT advice was obtained and followed for when people

were at risk of choking and needed softened food and thickened drinks to minimise this risk.

Good

Is the service caring?

Our findings

We found that people were being looked after in a caring way. People told us that they were well-looked after because staff were kind and caring. One person said, "I think these people [staff] are very kind." One 'thank you' card, sent in by a person's relatives, read, "We thank you for the wonderful compassionate care given to our dear [family member]…" We saw that the quality of members of staffs' engagement with people was done in a respectful way. This included going up to the person and talk to them at eye-level. Furthermore, there was a lot of social conversation and laughs. One person said, "I can have a laugh with anyone [staff] here." Another person said that they liked the staff and got on well with them.

The local Healthwatch team reported that people told them that they were satisfied with how they were being looked after. This included, for example, how staff respected their privacy and dignity. In addition to this, the local Healthwatch team noted that people were given the opportunity to personalise their own rooms with their own personal possessions. These included, for example, ornaments and photographs. The local authority contracts monitoring officer told us that they had no concerns about how people were being cared for.

The premises maximised people's privacy and dignity. All rooms were used for single occupancy only and all communal bathing facilities were provided with lockable doors. We saw that people were provided with personal care and support out of view. In addition to this we heard and saw staff reassuring a person following a fall that had taken place in one of the communal lounges. Staff had closed the lounge door whilst helping the person back to their chair by means of a hoist.

People's right to choice was valued. Care and catering staff were aware of offering people choice. This included, for example, providing people with their day-to-day personal care and offering choices in relation to menu options. Most but not all of the people told us that their choice of when to get up and go to bed was valued. One person told us that they got up at the usual time of six o'clock. Another person said that they were helped to get up after they had woken up and was helped back to bed when they wanted to. However, two people said that they were not always helped back to bed at the time when they wanted. One person said that the previous evening they were "late" going to bed as they had to wait for staff. We brought this issue to the attention of the SMT.

People's independence was maintained and promoted. The agency member of care staff said, "Sometimes [name of person] will eat but other times we have to help [person]." We saw people were supported to maintain their independence with eating and drinking. This included staff prompting and encouraging people to do this task for them self. People were also encouraged to maintain their independence with walking. If needed, people had access to walking aids to carry out this exercise, safely and independently.

People were supported to maintain contact with friends, relatives and were able to make new friends. One visitor said that they were able to visit their friend [person] "any time". We saw people receiving their guests in the privacy of their room or in the communal lounges. One person told us how they had made friends with another person living at the home. We saw how they shared a joke and interests, which included playing

darts and solving word and picture puzzles.

Information about advocacy services was publicly available. The compliance and quality and education manager was aware of the local services available in the event of any person requiring these services. Advocacy services are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

We found that people were being looked after in a way that their individual needs were being met. People told us that they were satisfied with how their needs were being met. One person said, "They [staff] are looking after me very well." Another person said that they were now more comfortable due to a change of seating. Their visitor told us that this change had improved how their friend's needs were now being met. They said, "It's got a lot better. They [person] used to be quite unsettled." We saw that the person was sitting comfortably in their reclining chair which they were able to operate independently. Another person said, "They [staff] are looking after me very well." One agency member of care staff described how they supported a person with their daily personal care and continence needs. They described how this was carried out and we saw that this was in line with the person's planned care.

Some of the people living at the home were living with dementia which affected their communication needs. One person with this condition had photographs to look at to understand what was being said to them. In addition to this communication aid, members of care staff had an understanding of how people communicated their needs. One agency member of care staff said, "Sometimes [person] plays with clothing and then I know they want to go to the toilet." The registered manager had a clear understanding of people's individual needs, including how they communicated their needs by individual patterns of speech. We heard staff talk to people in a way that they could understand. This was by means of talking to them in short sentences so that the person was able to process the information and know what was being said to them.

People told us that they believed staff knew them and their life histories which showed that people were seen as unique individuals. Information about people's life histories was obtained and recorded. The compliance and quality and education manager advised us that this information was being reviewed. This was to tailor people's interests and hobbies to the provision of individual recreational activities. They gave an example of the progress of this: one person engaged in an activity of assembling plastic bricks which was a simulation of the person's previous employment. People told us that they had enough to do. One person said, "There's nothing much I want to do. Although I do like to watch the six o'clock evening news on the television." Another person said that they had plenty of things to do and they were looking forward to events for the forthcoming festive celebrations. These included, for example, a pantomime and singing by visitors to the home.

People's needs were assessed and care was planned and provided to meet such needs. Although people who we spoke with were unable to recall their admission to the home, the registered manager told us about this. They said that they obtained pre-admission assessments, including assessments of people's risks of falls, before the person moved in. This was to ensure that the services provided at the home would be able to meet the person's assessed needs.

In order to ensure that, once in the home, people's needs continued to be met, the registered manager carried out reviews of people's planned care and risk assessments. This was at least once a month, if not sooner to ensure the person's planned care remained appropriate to their needs. When people's needs

changed, their care plans were reviewed. The registered manager advised us that the reviews would also include the person; their relatives, and external health and social care agencies to review more complex care. This was in order to ensure that the home remained a suitable place to meet people's changed level of needs. The registered manager advised us that they had plans in place, for December 2016, to review other people's care plans with people and people who were important to them.

People's care plans and risk assessments were up-to-date. Members of care staff said that they had the right amount of recorded guidance to enable them to meet people's assessed needs. One member of care staff said, "I find the care plans are easy to 'navigate' due to their layout. The information is available." The agency member of care staff said that they, too, found the care plans were "easy-to-follow."

People's individual religious beliefs were respected. One person said that they were looking forward to attending services to celebrate the forthcoming festive celebrations. Another person said that they had visits every week by representatives of a religious organisation which they belonged to. The visits were so that the person was able to practice their religious beliefs. The chef advised us that at the time of our visit there was no person who required special cultural diets, such as halal or vegetarian diets.

We checked to find how the provider responded to any complaints raised. People knew who to speak to if they wanted to raise a concern or complaint. They knew the names of individual members of the SMT. They said that these were the people, who they would speak with, if needed. One member of care staff said, "Residents [people living at the home] and relatives know us so well and will come up to us of there is a slight issue that we can resolve." They were aware of listening and reporting any concerns to the registered manager if these, or complaints, were beyond their remit to deal with.

Complaints were recorded and the registered manager had taken remedial action in response to an emerging theme. They told us that this action had reduced the incidents of people entering, uninvited, into other people's rooms. They said that this was kept under review. One person told us that that they were unhappy about how their personal clothing was laundered. The registered manager told us that they had identified the cause for this. They said that they would discuss this further with other members of the SMT as this was an identified area to improve.

Good

Is the service well-led?

Our findings

We found that people benefited from living in a well-managed home. People knew who the registered manager was and we saw the presence of the registered manager as they walked and worked around the home. When doing so they interacted with staff, people and visitors, as a two-way process, and this interaction showed that they were approachable..

The registered manager was respected and valued by members of staff. They told us that the registered manager would listen and respond to their requests This included staff requests for a change in the patterns of their work to improve their work-life balance. The member of the laundry team gave another example of how they were listened to. They said that they had asked the registered manager for a larger ironing board; their request was granted without delay. The chef told us that they had requested a piece of kitchen equipment and this order was sent, without hesitation, by the registered manager to the provider to approve. As a result of this and the leadership style of the registered manager, staff felt valued. The registered manager told us that the staff team was stable, without a turnover of staff, and therefore people's individual needs were met in a consistent way.

The compliance and quality and education manager said that they found the team of staff were motivated to learn more. As a result of what staff had said, a full training programme was in place. This included training in resuscitation procedures and forthcoming training for 2017 in topics such as dementia and diabetes.

As well as staff being listened to, people and their relatives were also provided with opportunities to share their views about the quality of their care. Minutes of meetings held during 2016 showed that people had made suggestions in relation to the menu. The registered manager said, "People can have any menu they [people] want and we have not offered yet." The provider had carried out telephone interviews to obtain relatives views about the quality and safety of the service provided. One of the directors advised us that the results of these were positive with no remedial actions to be taken. They told us that they next telephone survey was arranged to take place during December 2016.

Audits were carried out and action plans were drawn up as part of the provider's quality assurance system and improvement plans. During October 2016 an audit had been carried out by an external consultancy firm. The compliance and quality and education manager said they had drawn up an action plan, based on the audit. The directors told us that they had just received the action plan and this was yet to be seen for their approval. Other audits were carried out and this included audits of people's care records and medicines. The provider had an action plan in place and this showed that most of the actions had been completed and signed off. Where other actions had yet to be completed, the dates for this completion had not yet passed. This showed that the provider had robust quality and monitoring systems in place to ensure that people were provided with safe and quality care.

Required notifications had been submitted which told us that the registered provider and registered manager were aware of their legal responsibilities. These notifications were in relation to, for example,

deaths and DoLS applications made and authorised by the appropriate authorities.

There was an open and transparent culture which operated in the home. An example of this was in relation to whistle blowing. One member of care staff demonstrated their knowledge about the whistle blowing policy and procedure. They said, "I know there is a particular 'phone number and you can use this number if you witness any harm [of a person]. Or anything you are not comfortable with. You could do this anonymously or confidentially." One of the directors told us that staff had access to both an internal and external whistle blowing telephone line, if needed. Members of care staff said that they would have no reservation raising their concerns by following the whistle blowing procedures.

Another example of the open and transparency culture of the home was demonstrated by home's links with the community. Representatives from local schools and religious organisations visited people at the home. One person said, "We've got school children coming in to sing carols. And the Salvation Army. And people from a local church."