Tarvin Estates LLP

Tarvin Court

Inspection report

4 Tarvin Road,
Littleton,
Chester
CH3 7DG
Tel: 01244 336533
Website:

Date of inspection visit: 9 July 2014
Date of publication: 29/12/2014

Ratings

Overall rating for this service	Requires Improvement
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?	Requires Improvement

Overall summary

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, and to provide a rating for the service under the Care Act 2014.

This inspection was an unannounced. The previous inspection was carried out on 5 June 2013. All areas reviewed met the current regulations.

Tarvin Court is a nursing home that provides accommodation for up to 28 older people who require personal or nursing care. It is situated in Littleton on a main bus route into Chester. The property is a two storey building with a single storey extension at the back. There are 22 single rooms and 3 double rooms.

There is a manager who has been in post for a year. They are currently applying to be registered with CQC. A

Summary of findings

registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

We found that some improvement was required at Tarvin Court. Staff training, professional development, supervision or appraisals needed to be brought up to date. Therefore some staff did not have the relevant or up to date training and supervision to enable them to support the people who lived there.

People told us that they were happy living at the home and they felt that the staff understood their care needs. People commented "The girls are busy, they do work hard", "There are some good nurses here" and "They are marvellous here."

We found that people, where possible were involved in decisions about their care and support. Staff made appropriate referrals to other professionals and community services, such as the dietician, where it had been identified that someone was losing weight. We saw that the staff team understood people's care and support needs, and the staff we observed were kind and thoughtful towards them and treated them with respect.

The home was clean, hygienic and well maintained.

Records showed that CQC had been notified, as required by law, of all the incidents in the home that could affect the health, safety and welfare of people.

We looked at the care records of three people who lived at Tarvin Court. There was detailed information about the support people required and that it was written in a way that recognised people's needs. This meant that the person was put at the centre of what was being described. We saw that all records were well recorded and up to date.

We found Tarvin Court had systems in place to ensure that people were protected from the risk of potential harm or abuse. We saw the home had policies and procedures in place to guide staff in relation to the Mental Capacity Act 2005 and deprivation of liberty safeguards, safeguarding and staff recruitment. This meant that staff had documents available to them to help them understand the risk of potential harm or abuse of people who lived at Tarvin Court.

We found that good recruitment practices were in place and that pre-employment checks were completed prior to a new member of staff working at the service. This meant that the people who lived at Tarvin Court could be confident that they were protected from staff who were known to be unsuitable.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

We found the service was not safe and required improvement.

We found that staff had not received up to date training, supervision and appraisals. This meant that some staff did not have up to date skills, knowledge and support to enable them to care for the people who lived at Tarvin Court.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The home had policies and procedures in relation to the MCA and DoLS. One application was in place. Only the manager had been trained to understand when an application should be made. No staff had received training on the MCA or DoLS.

The service was clean and hygienic. Equipment was well maintained and serviced regularly which ensured people were not put at unnecessary risk.

On examination of staff records we found that the recruitment practice was safe and thorough. Policies and procedures were in place to make sure that unsafe practice is identified so that people are protected.

Is the service effective?

Good

We found the service was effective.

Many of the people were unable to tell us if they were involved in decisions about their care and daily life activities due to their level of dementia. We saw that staff encouraged people to make decisions on day to day tasks and that staff were kind, patient and caring.

Visitors confirmed that they were able to see people in private and that visiting times were flexible.

Is the service caring?

Good

We found the service was caring.

People were supported by kind and attentive staff. We saw that staff showed patience and gave encouragement when they supported people.

We saw that people were well cared for. They told us that they spoke to staff about their preferences, and that this was undertaken in an informal way. Everyone commented on the kindness and gentleness of the staff at Tarvin Court. People told us that their dignity and privacy were respected when staff

Summary of findings

were supporting them, and particularly with personal care. We saw that staff addressed people by their name and we heard staff explaining what they were about to do and ask people if it was alright before carrying out any intervention.

Is the service responsive?

Good

We found the service was responsive to people's needs.

People regularly took part in a range of activities in and outside the home.

People's health and care needs were assessed with them and with their relatives or representatives where appropriate. People were involved in writing their plans of care. Specialist dietary, mobility and equipment needs had been identified in care plans where required. People and relatives we spoke with said that they had been involved in writing them and they reflected their current needs.

People knew how to make a complaint if they were unhappy. People said they did not have any concerns or complaints. We looked at how complaints would be dealt with, and found that on recent complaints the responses had been thorough and timely. People can therefore be assured that complaints are investigated and action is taken as necessary.

Is the service well-led?

Requires Improvement

We found the service was not well led and required improvement.

The service had a manager in place, who had been working at the service for a year and who had recently applied to be registered with the Care Quality Commission.

We spoke to people who lived at the home and visitors about the staffing levels and management team. They said "The staff are lovely and very kind" and "The girls are very busy, they do work hard."

The service worked well with other agencies and services to make sure people received their care in a joined up way.

The service had a quality assurance system to monitor the service provided. Records seen by us showed that identified shortfalls were addressed promptly. As a result the quality of the service continued to be monitored to ensure standards are maintained.

Tarvin Court

Detailed findings

Background to this inspection

We visited Tarvin Court on 9 July 2014.

Before our inspection, we reviewed all the information we held about the home. This included notifications received from the manager and we checked that we had received these in a timely manner. We also looked at safeguarding referrals, complaints and any other information from members of the public. We contacted the local safeguarding team and the local authority contracts team for their views on the service. They confirmed that they had no concerns regarding Tarvin Court.

During our visit we spent time observing care in the dining rooms and used the short observational framework (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We used this observational tool as some of the people who lived at Tarvin Court were living with dementia. We looked at all areas of the building, including people's bedrooms and the communal areas. We also spent time looking at records, which included three people's care records, four staff recruitment files and records relating to the management of the home.

On the day of our inspection, we spoke with 15 people who lived at Tarvin Court, three relatives who were visiting the home, a visiting professional, the manager and four members of the staff team.

The inspection team consisted of an adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The last inspection was carried out in June 2013. At that time we found that all areas we reviewed were met.

Requires Improvement

Is the service safe?

Our findings

Many of the people who lived at Tarvin Court had a diagnosis of dementia and although staff were caring, staff did not have knowledge and understanding of caring for people living with dementia.

We looked at other staff training and found that 15 out of 35 staff did not have up to date moving and handling training which meant there was a potential that people who used the service were not supported with moving and handling by staff who were adequately trained. We saw that 18 out of 35 of staff had not received training in safeguarding. Therefore there was the potential for staff to be unaware of what to do if they suspected abuse was taking place.

We recommend that training is brought up to date.

We looked at staff rotas over the last four weeks, which showed the staffing levels at the home. We saw that one nurse, one senior care assistant and three care assistants worked during the day and at night there was one nurse and two care assistants on duty. The manager said these staffing levels currently met the needs of the people. The manager confirmed that they currently had four staff vacancies for a nurse, two care assistants and a kitchen assistant. However, the care assistants and kitchen assistant's posts had been filled and staff were waiting to commence employment once all recruitment checks had been carried out. The manager said they usually managed to cover shifts with staff who were prepared to do overtime, the home's bank staff or by using a local agency. People who lived at Tarvin Court said "There are some good nurses here" and "They are marvellous here." We saw during the day that there were sufficient staff to support people when they required. Call bells were answered promptly and people's needs were attended to in a timely manner.

We looked at how the home responded to safeguarding people who lived there. We saw that one allegation of abuse had been reported and manager had responded well in this process. We saw that staff had access to a range of policies and procedures which included safeguarding people who use services from abuse and the local authority policy and flow chart. They also had policies on whistle blowing and were able to report to bodies outside the organisation if staff had a concern. We saw the staff training for safeguarding adults required improvement.

Some staff told us they had received training in safeguarding adults. We spoke with staff on duty who had undertaken the training, they were able to tell us the right action to take so that people were protected.

We had a discussion with the manager regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and they confirmed they had a copy of the Act's codes of practice and understood when an application should be undertaken. We asked if anyone had a DoLS in place and the manager confirmed that one application was in place. We looked at the documentation and saw that good records had been kept and that reviews had been undertaken with the Independent Mental Capacity Advisor (IMCA). During the last review the IMCA stated "I am happy with the care provided." We saw that the manager had received training in the MCA and DoLS and they confirmed they received regular updates in meetings they attended. However training on the MCA 2005 and DoLS required improvement for the staff team as none of the staff had attended any training in this area. Staff spoken with were not able to tell us how the MCA and DoLS related to care they currently gave, or about 'best interest' decisions that may be needed when a person lacks capacity to make decisions for themselves. We noted that the home had policies and procedures in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. From discussions with the manager and staff it was evident that only the manager understood assessments of capacity were needed, and therefore improvement in staff training was required. Staff were not aware of the importance of people being supported to make decisions or how to assess when intervention would be required and how the assessment process would be undertaken.

We looked at recruitment records of four staff members and spoke with staff about their recruitment experiences. We identified that recruitment practices were safe and that relevant checks had been completed before staff worked unsupervised at the home. This meant that people were protected from staff who were known to be unsuitable to work with vulnerable adults.

Recruitment of new staff had been undertaken however some posts were still vacant. The manager explained that staff usually covered for each other and bank staff

Requires Improvement

Is the service safe?

supported them. Occasionally they used a local agency. We saw on the staff rotas that staff worked overtime to cover most of the shifts and that agency staff also were employed to cover shifts within the home.

Staff confirmed they had completed an induction at the beginning of their employment and records confirmed this. The induction programme was used to ensure staff understood the organisations policies and procedures and expected conduct. The programme was aimed at staff's particular role within the company. They said they also undertook shadowing shifts to see how tasks were completed and what was required from them. This meant that staff had the opportunity to develop their skills and knowledge to enable them support the people who lived at Tarvin Court. We spoke with four staff members during this visit. Three people had worked at the home for a number of years.

We looked at three people's care plans and risk assessments and found these were well written and up to date. Risk assessments had been completed with the individual and their representative, if appropriate for a range of activities. These identified hazards that people might face and provided guidance on how staff should support people to manage the risk of harm. Risk activities included moving and handling, falls, nutrition and medication.

Tarvin Court was clean and hygienic. Equipment was well maintained and serviced regularly which ensured people were not put at unnecessary risk.

Good

Is the service effective?

Our findings

Many of the people who lived at Tarvin Court could not tell us if they were involved in decisions about their care due to their level of dementia. However, we observed people were involved in decision making in many aspects of their daily life. For example people were asked what they would like to eat, what clothes they would like to wear or if they wished to join in an activity.

Family and friends confirmed they were consulted and felt involved. People commented "We, the family are very pleased", "My friend is well cared for." Visitors confirmed that they were able to see people in private and that visiting times were flexible.

We spoke with four staff who were knowledgeable about the people in their care and the support required to meet their needs. We observed both as part of the SOFI observations and on an informal basis that the three staff on lunch duty were very attentive to people's needs, some of whom needed assistance with eating. They talked to them in friendly fashion as they served the food. Most of the people in the dining room were in wheelchairs and they were assisted back to the lounge after lunch. We saw that people had to wait for quite a while before being hoisted into an armchair. One person commented that "I wished they were faster, because their back became very painful if they were left too long in the wheelchair." This meant that some people were sitting in a wheelchair for a long time and this may be uncomfortable for them. Staff should monitor this to ensure people are assisted into a more comfortable chair in a timely manner.

People discussed their health care needs as part of the care planning process and told us they would tell the staff if they felt unwell or in pain. On looking at people's care plans we noted there was information and guidance for staff on how best to monitor people's health. This meant staff were aware of people's healthcare needs and knew how to recognise any early warning signs of deterioration in health. We noted records had been made of healthcare visits, including GPs and the chiropodist. People confirmed the staff contacted their doctor when they were unwell. We spoke to a health care professional during our visit who said "The people here appear well cared for. I visit regularly and the manager is very professional."

During our observations we saw that staff communicated well with people at Tarvin Court. Staff responded well to people's needs and were patient and kind and gave people time to make decisions for themselves.

The daily record sheet was completed during each shift. This showed the care and support each person had received and also included information about their wellbeing. We saw that the GP and other professional's attended the home and this information was included in the care records. Professionals included GP's, chiropodists and social workers. Hospital appointments were also documented.

We saw that people had their needs assessed and that care plans were written with specialist advice where necessary. For example care records included an assessment of needs for nutrition and hydration. Daily notes and monitoring sheets recorded people's needs across the day and provided current information about people's support needs. When a person's need for extra nutritional support was identified, specialist advice was sought by the appropriate professionals

We observed that staff were aware of people's preferences throughout the day. During the lunchtime we saw that people were offered a choice of meals. For example if people didn't want the meal on offer the staff would suggest an alternative that they could have. All the people we spoke with at lunch spoke well of the food and made the following remarks "Not bad at all" and "Pretty good" and "Really good, you can't knock it." This meant that staff had the knowledge they needed to support people in line with their wishes.

We spoke with the cook and found they were aware of the needs and preferences of the people who lived at Tarvin Court. They enjoyed their work and had no concerns about the service. There was a four weekly menu, which provided mostly traditional foods. The cook confirmed there were always alternatives people could have if they didn't like the main meal. We saw that there were two choices of meals at lunchtime and that some people had chosen the alternative meal on offer. People commented "The food is pretty good" and "It's really good, you can't knock it."

Good

Is the service caring?

Our findings

We spoke with 15 people living in the home and asked them how they preferred to receive their care. They told us that they spoke to staff about their preferences, and that this was undertaken in an informal way. Everyone commented on the kindness and gentleness of the staff at Tarvin Court. This meant that people who lived at the home were treated with dignity and respect and their views on the way their care and support should be provided was listened to.

People told us their dignity and privacy were respected when staff were supporting them, and particularly with personal care. For example personal care was always undertaken in the privacy of the person's own bedroom or the bathroom, with doors closed and curtains shut when appropriate. We saw that staff addressed people by their preferred name and we heard staff explaining what they were about to do and ask people if it was alright before carrying out any intervention. One person said "The staff are very good here."

We saw two of the care staff assisting a person to move from their wheelchair to a chair in the lounge. The staff lightened the atmosphere with singing and laughter with the person to help them not feel embarrassed by the action being taken. This seemed to work well for this individual and showed that people were treated with dignity and respect by the staff team.

We observed people to gather information about the experience of care from the point of view of people who used the service, alongside other information we would usually gather during an inspection. As part of this we also spent some time in the dining rooms and lounge areas. We saw good staff interaction with people. Staff were caring, kind and gave people time to make decisions for themselves. We also saw staff offer people a hand or arm to steady them and they would always ask if that was alright rather than just taking over. We heard staff say "Shall I take your arm – that's it just hold onto my arm so you don't fall."

We saw that staff showed patience and understanding with the people who lived at Tarvin Court. They spoke with people in a respectful and dignified manner. We saw good interactions throughout the day and all the staff we observed showed dignity and respect to people who lived at Tarvin Court.

Good

Is the service responsive?

Our findings

We looked at three care plans and other care records for people who lived at Tarvin Court. The care plans were well written and provided guidance on the care and support people needed and how this would be provided. The care plans were written in a way that recognised people's needs. This meant that the person was put at the centre of what was being described. Each person's file contained a copy of the care plan and risk assessments, which we saw were up to date.

We saw that the care plan documentation included records of discussions held with people who lived at Tarvin Court and their relatives which included pre admission discussions about the care and support people required. Information on the life of an individual was also discussed and recorded. Records showed that how a person preferred to be addressed had been discussed and was noted in the care plan record. For example one person preferred to use their middle name and another preferred a "familiar nickname" instead. This showed that staff had found out information about people's past to enable them to care and support people as they wished.

Information on social histories was included in the care plan documentation. This also included activities that people had been interested in during their life and a social profile to assist staff in offering activities that people had undertaken in the past, as well as encouraging the opportunity to try new activities. The staff we spoke with told us this information helped them to understand the person.

The risk assessments had been completed for a wide range of activities including moving and handling, falls, nutrition, pressure area care and continence. These identified hazards that people might face and provided guidance upon how staff should support people to manage the risk of harm. We saw that falls risk assessments had been undertaken and where a high risk was identified further intervention was sought and specialist equipment put in place to reduce the risk.

We saw that tables had been laid with a range of cutlery that met different people's needs. This meant that people were able to eat independently and that dignity and respect was maintained for people who lived at Tarvin Court.

People were offered a range of social activities across the week. We saw evidence that activities were regarded important to an individual's well-being. There was an activities board in the corridor which showed the activities available. These included a regular external entertainer, films, skittles, manicures, bingo and crafts. Other activities included flower arranging, puzzles, painting and baking. A hairdresser visited weekly and the mobile library visited on a monthly basis. We saw that holy communion and other religious services were available at the home.

Visitors we spoke with said they would feel confident in raising issues with the manager if they needed to. One visitor said that they never had to complain. We saw that four complaints had been received since the last inspection. These had been fully recorded and resolved satisfactorily within 28 days. This meant that people could be confident their views would be listened to and acted upon.

We saw that the home had received a range of compliments, which included thank you cards and letters. Comments included "We are extremely grateful for all the kind care and consideration you have shown us", "Thank you for your care and kindness", "We are made so welcome when we visit" and "Thanks for all the tender car you gave my father during the last months of his life."

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection visit the manager had been in post for a year. An application for registration had been received and they were currently applying to be registered with the Care Quality Commission (CQC).

We saw that training, supervision and appraisals were not up to date and required improvement. Staff should have access to appropriate training and supervision sessions to enable them to discuss their role, the service and future training needs with their line manager. 8 out of 35 staff had received supervision in the last three months and 12 out of 35 staff had an up to date annual appraisal. The manager confirmed that these needed to be brought up to date.

We saw that regular meetings took place with the staff team. Usually the meetings were held within specific staff groups such as general staff meetings and qualified staff meetings. Meetings had been held in February and March. Records of these meetings were kept and seen during the inspection.

Observations of how the manager interacted with the staff and comments from staff showed us that the leadership was good and a positive influence on the home. We also spoke to people who lived at the home and visitors. They said “The staff are lovely and very kind”, “These girls are fantastic” and “I can’t fault them.” Staff said “I like working here” and “The staff team is a good one.”

We spoke with a visiting professional who commented, “The home is small and the people get continuity of care. The manager is good and very professional. The staff are nice and helpful. People appear well cared for.” We also spoke with the local safeguarding team and local authority contracts team. They both confirmed they had no concerns about this home. This showed the service worked well with other agencies and services to make sure people received their care in a joined up way.

CQC had been notified of relevant incidents since the last inspection. These are incidents that a service has to report and include expected deaths and injuries. We saw that the notifications had been received shortly after the incidents occurred which meant that we had been notified in a timely manner.

We spoke with staff about their roles and responsibilities. They explained these well and were confident they knew their responsibilities to the people who lived at Tarvin Court and the management team.

We saw the home had a system in place to monitor and review the service provided. This was completed on a monthly basis and included information about pressure ulcers; infections; dietary needs; continence; medication errors; hospital admissions and accidents. We saw that audits were also carried out on the medication system. The last one was completed in February 2014. When action was needed this was documented on the audit and record of when it had been addressed kept. On examination of the last two audits no action plans had been required. The manager explained they reviewed this information and used it to inform and improve the service provided.

People who lived at Tarvin Court and their relatives had the opportunity to attend meetings on a regular basis. The last meeting was in March 2014. Issues discussed included meals, activities, decoration, provider visits and new staff appointments. People confirmed they were happy with the redecoration and one person said they could do with an extra toilet downstairs. The manager agreed to discuss this with the owners. This meant that people had the opportunity to discuss issues with the management, and that the home had sought the views of people who lived at Tarvin Court.