Slough Borough Council

Lavender Court

Inspection report

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17 October 2018
18 October 2018
22 October 2018
30 October 2018

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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**

Summary of findings

Overall summary

Lavender Court is a 'care home' without nursing. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Lavender Court provides adapted accommodation and care for up to seven people with learning disabilities. At the time of our inspection there were seven people using the service, supported in the home by 17 permanent staff. Some of these staff were allocated to the home from another service which was closed for refurbishment. At the time of the inspection there were plans to rota the staff across the two services when it re-opened in the new year.

The property is a large bungalow with seven bedrooms, communal spaces, a rear garden and is close to local amenities. The home was closed between January to July 2018 for a refurbishment project which adapted the premises for people with mobility needs and to provide en-suite facilities.

This inspection took place on the 17, 18 and 22 October 2018. We returned on the 30 October 2018 to provide feedback to the registered manager and operations manager who were both on annual leave during our inspection on the 22 October 2018. The inspection was unannounced on the first day of inspection which means we did not provide the service with warning of our visit. Subsequent days were announced.

The provider is required to have a registered manager as part of their conditions of registration. 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. At the time of our inspection, there was a manager registered with us.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At our last inspection we found breaches of Regulation 12 (Schedule 3), 15 and 18 of the Registration Regulations 2009 and Regulations 9, 12, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service received an overall rating of requires improvement.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question(s) safe, effective, responsive and well led to at least good. At this inspection we found there were repeated breaches of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have satisfactory arrangements to manage individual's risks and safety. Records were not suitably maintained, accurate and

up to date and the governance of the service failed to bring about the improvements required for them to become compliant.

Systems did not always ensure that vulnerable adults were protected from foreseeable risks. People's risk assessments were completed but were not always clear or accurate and did not contain sufficient information to identify or mitigate risks. The service did not use an effective method to calculate staffing deployment.

The governance of the service was unsatisfactory. A quality assurance tool had recently been developed but was not comprehensive, and not always acted on promptly or sufficiently. Records were not always up to date or appropriately filed. There was not sufficient day-to-day management oversight of the home or enough time allocated to senior staff to achieve delegated management duties.

The service had made improvements to staffing levels which meant people were supported to be safe. The service did not use an effective method to calculate staffing deployment. Staffing was based on people's funded care, and not their individual needs or dependency. We have made a recommendation about this.

The service did not have a specific safeguarding policy and procedure and we have made a recommendation about this. People were safe from abuse. Staff were able to identify abuse and signs of abuse and understood how to report concerns to management. Medicines were managed and administered safely. Recruitment checks were completed as required.

People's health and wellbeing needs were met. The service worked closely with clinicians and other professionals and followed advice and treatment plans effectively. Staff understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and the principles of gaining consent or making decisions in peoples' best interests. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

The service provided a friendly atmosphere and staff demonstrated kindness and commitment to people's welfare. Staff approaches were respectful of privacy and dignity. People's relatives and relevant others were consulted to make decisions in people's best interest, where people lacked capacity to consent. Care plans were person-centred and responsive to individual's current and changing needs. People were supported to follow their interests and work towards their own goals.

You can see what action we told the provider to take 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 was not always safe.

People's risks were not clearly identified or mitigated.

Premises risk and safety records were not always up to date.

Staffing levels had increased which was an improvement.

People were protected from abuse or neglect.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

The service had made improvements to staff training, supervisions and appraisals.

The service was compliant with the Mental Capacity Act (MCA) 2005.

People were supported to access healthcare services.

Is the service caring?

Good

The service was caring.

People were treated with kindness.

Care plans included people's individual wishes and preferences.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People's care plans were person-centred and comprehensive.

Staff had good knowledge and understanding of people's needs.

People's access to opportunities in line with their interests in the home and the community had improved.

Information about and in response to complaints was clearly documented which was an improvement.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

Records about people's care and service safety checks were not always up to date or filed appropriately.

Audits were not used effectively to monitor the quality and safety of the service.

There was not sufficient day-to-day management oversight of the home.

There was not a robust system to investigate or share outcomes of incidents and accidents to ensure learning took place.

Lavender Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 17, 18 and the 22 October. We returned on the 30 October to provide feedback to the registered manager and operations manager who were both on annual leave during our inspection on the 22 October. The inspection was unannounced on the first day of inspection which means we did not provide the service with warning of our visit. Subsequent days were announced.

Before the inspection we looked at all the information we had collected about the service. The service had not submitted any notifications to CQC. A notification is information about important events which the service is required to tell us about by law. We received and reviewed a provider information return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted a range of health and social care professionals including commissioners, advocates and a dietitian but did not receive any feedback.

During our inspection we spoke to the registered manager, two senior staff, one agency care worker and three permanent care workers. We observed staff supporting seven people who were at home at various intervals of the inspection visits. People who were at home were unable to provide us with any verbal feedback about their experience of the care provided. We used observations to gain an understanding of staff interactions and engagement and the care people received.

We looked at four people's care plans, risk assessments and other records that were used by staff to monitor their care and treatment. We also checked duty rosters, recruitment records, menus, accident and incident forms and records used to measure the quality of the service, including health and safety checks, electronic records of people's daily lives and medical appointments as well as service audits.

We received further written feedback from three staff members after the inspection and spoke with three family members of the people supported. We also received further feedback and information about training,

staff checks and service health and safety checks from the management team after the visit.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection the service was in breach of Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because safe care and treatment was not always provided, and safe numbers of staff were not deployed. We asked the provider to send us a report to tell us what actions they planned to take.

At this inspection we found a continued breach of Regulation 12.

The service assessed general and specific areas of risk such as falls, epilepsy, behaviours that challenge and fire evacuation, but this information was not comprehensive or up to date. Risk assessments identified the "likelihood of occurrences" but did not identify the severity of risks so it was difficult to understand risk priorities. Efforts had been made to review risk assessments, dated September 2018, and the registered manager added hand-written corrections. However, there was not a time specific plan for this to be typed-up and notes were not legible, neither did they address gaps in relation to hazards or safe measures to mitigate risk. Two risk assessments repeated information about the person's behavioural and mobility risks and were both confusing to follow. One staff member told us the person used orthotic inserts to support their mobility and prevent falls, but this was not in the person's falls risk assessment. There was reference to a rollator walking frame to help the person mobilise within the home, but we did not observe the person using this during the inspection visit. We were told this was not necessary because they were currently very calm and had not experienced any falls. The risk assessments did not differentiate between the person's needs when they were calm or experiencing a period of crisis. Another risk assessment stated the person had "recently fallen and sustained a broken bone in [the person's] thumb". This was contradictory to what we were told. We looked at accident and incident documentation for 2018 which did not include the event; records before this were not available. The registered manager concluded this was a historic occurrence which was not accurately described within the current risk assessment.

Risk assessments were not cross-referenced with a person's behavioural guidelines and there was contradictory information about whether staff should use restrictive interventions. Staff were not provided with physical intervention training. Two staff members provided different accounts of how they should support a person when they were distressed and at risk of harming themselves and others. One said they would withdraw other people from the environment to maintain safety. Another staff member referred to specific physical intervention and training they had received in the past, but they were not sure if this was currently an agreed strategy. We discussed this with the registered manager who clarified the person was currently very calm and did not need physical interventions. They had identified the need for accredited physical intervention training and said they would prioritise this as an urgent requirement with the training department.

We saw that portable appliance (PAT) tests for electrical equipment were completed in August 2018 and there was an in-date electrical wiring test certificate with remedial actions identified. We were told these had been completed by the maintenance contractor, however there was no audit trail for us to check. There was a legionella prevention monitoring system, but records were missing from the log book. This was not in line

with the provider's "Legionella Risk Management Guidance", which said records were held on site and must be easily accessible at all times. We asked for records to be sent to us after the inspection and received sampling and treatment records up to December 2017. We could not check whether sampling or appropriate actions required by the provider had been completed since then.

The service approach to assessing and managing individual's risks was a repeated breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found the service had improved staffing levels which meant people were supported to be safe. This meant the service was no longer in breach of Regulation 18.

One relative said that staffing had improved from being unsafe but commented this was only because all staff were currently being utilised in one service for seven people whilst the other service was being refurbished. They were concerned that people were not always able to access opportunities in the community as frequently as they would like and commented that the service; "still can't rota staff appropriately and I am very worried when the other service reopens. The rota is not designed to meet individual's one to one needs, it is staff-led". Two relatives were concerned the reduction in staff would lead to a deterioration in their family member's emotional and physical wellbeing, with comments such as; "there is no communication about staffing [the registered manager] only addresses the refurbishment. I disagree with their priorities. Funding should be directed to improve staffing levels."

Staff told us that staffing numbers had improved this year and they were able to take people to more activities and felt there were enough staff to keep people safe. However, they were concerned about the impact of the staff numbers reducing when the other service reopened and believed this would impact negatively upon service user's safety and wellbeing. Throughout the inspection visit we observed staff support people to external activities and remaining staff were mostly able to respond to people's needs within the home. There were times during handover periods where people were not supervised or supported. We were told that some people were not funded for one to one support and were assessed as being able access the home safely and procedures were in place to reduce kitchen hazards. We checked the home's shift plans and could see the template included staff allocation against every person for "personal care and cleaning bedroom", "responsible for regular toileting" and "planned activities". Meal time one to one support was not included on the template and there was no consideration for who was responsible for one to one support at other times of the day. There were often gaps on the shift plan where staff names were meant to be recorded. This meant it was not clear which staff members were responsible for supervising the health and safety of individuals throughout the day. However, we observed that staff communicated and co-ordinated peoples' care and support verbally and were clear about who they were supporting at key times.

We checked the rota for the month of October 2018 and saw that four staff were deployed in the morning and afternoon and a shift leader was identified every day. Agency staff were used daily to cover staff annual leave and classroom training. A contract was in place with a regular agency which meant familiar agency staff were rostered. We asked how the service planned cover for annual leave, training, supervision and time for paperwork. The registered manager was not aware of how the staffing establishment was calculated to include this coverage.

At the previous inspection it was found there was no use of satisfactory tools or appropriate calculations to determine what a safe staffing deployment would be. This continued to be the case during this inspection. The registered manager said they "need to work within the budget and number of staff I am given" and was not aware of individual's support hours in line with their dependency levels or individual needs. The rota was described to us by the registered manager as working around historic staffing commitments which

meant there was not as much flexibility as management would like. We spoke to the registered manager and operations manager about future staffing levels and deployment when the other service re-opened in the new year. The service was recruiting to two and a half full time vacancies, but future staffing levels had not yet been finalised. The operations manager confirmed that management had submitted a business plan to protect the number of staff currently working at Lavender Court when the other service reopened, however this was yet to be reviewed.

We recommend the service implements an appropriate tool to determine and evidence safe staffing levels and deployment. We also recommend the service records day-to-day staff allocation to confirm and evidence roles and responsibilities.

The service did not have a safeguarding policy and procedure, signage or other written guidance for staff to follow when reporting and recording safeguarding concerns. We were informed that the service followed the local authority's safeguarding policy and procedure which staff could access online. Staff said were not aware of how to access this document. Staff were able to identify signs of abuse and how to protect people from discrimination. They told us they would report concerns to the registered manager, or in their absence a senior member of staff or the operations manager. However, they were not aware of how to contact the local authority safeguarding department directly. The registered manager talked through the process of referring safeguarding concerns to the local authority and referred to the required alert form, which they would look-up on line if it was required. We contacted the local authority who confirmed they had not received safeguarding referrals from the service since our previous inspection and no safeguarding concerns had arisen.

People using the service were not able to tell us if they felt safe and so we asked for feedback from relatives. One relative said the service had responded to an incident and implemented safe measures to avoid this from happening again. Another relative said "Yes [the person] is safe there and they are doing well".

We recommend the service develops a specific safeguarding policy in line with best practice.

The service completed recruitment checks that ensured suitable applicants were appointed. We checked two staff recruitment records and found that proof of identity and right to work in the UK were not included in their personnel files. We were sent evidence of checks after the inspection. Staff profiles and Disclosure and Barring Service (DBS) numbers and dates, work history, relevant experience and qualifications were appropriately recorded in personnel files. We checked agency profiles and inductions. We saw completed inductions for agency staff who started prior to 2018, but three newer agency inductions were not on file. The registered manager said this may be due to their induction commencing in the other service and some records were in storage and inaccessible. We spoke to a new agency member of staff who said they were provided with an induction and "shadowed staff for over a week and read care plans". The person felt they were given enough time to get to know people and to understand service specific procedures.

We checked the medicines administration records (MAR) for two people which were completed in line with requirements. There was a robust system to check medicines administration at the time and at the next handover. We were told checks were effective and identified gaps of signatures which were then quickly rectified. However, discrepancies were not recorded, which made it difficult for the service to analyse and learn from trends to inform home procedures and staff support and performance management. We were shown an email from the operational manager who addressed signature gaps and instructed staff to following the correct protocol. One staff member was responsible for ordering medicines and demonstrated a thorough understanding of the procedure. They said the service regularly received the wrong medicines due to prescribing errors. This was picked up through the services' checking procedures and rectified

appropriately. We also found in our checks that there was a delay in one person's medicine being implemented because it happened mid-prescription cycle. The registered manager told us they were in the process of changing the GP surgery due to these issues. There was no log of errors and this had not been raised with the GP practice to learn what had gone wrong to improve procedures. The service had specific protocols for "when required" (PRN) medicine. These were kept in people care files rather than with MAR charts. Management took the decision to locate these protocols with the MAR charts, for ease of access, which was implemented during our inspection.

The medication policy and procedure, dated April 2018, was not in line with current national guidance and included inappropriate instructions. For example, it stated staff must not administer "un-prescribed" medication unless there is written permission from the GP or the unit manager. It would not be appropriate for the unit manager to authorise the use of "un-prescribed" or over-the-counter medicines without checking with a GP or pharmacist. The procedure also stated that if medicines were administered "late" staff were to record this and hand over to the next shift. There was no further instruction to seek advice from the prescribing clinician or to adjust the timing of subsequent medicines. This is important to ensure the appropriate levels, essential for the treatment of epileptic seizures. We saw that one of the medicines cabinets containing fluid thickening agents was left open. This was closed to by the registered manager who said there was no risk of service users accessing this. The cabinet was in the office which was always supervised when open and had a key pad entry mechanism in place. The medicines key was kept in an unlocked drawer in the office which all staff had access to. We discussed the security implications with the registered manager who showed us a key cabinet which they planned to fix to the wall as a priority to improve the security of keys.

We recommend the service seeks current best practice and follows national guidance in relation to the administration and management of medicines.

Risk assessments and safety records for the premises were not available during our inspection and were provided electronically after our visit. The fire risk assessment, dated July 2017, was not up to date as it was completed prior to the refurbishment. It identified several medium and high priority actions. There was a risk assessment action plan with a note that refurbishment work would address all identified fire safety issues. There was no audit trail to confirm items were actioned, however, the registered manager showed us works completed, for example, new fire doors and the ceiling was repaired. We were sent the most recent fire authority inspection report dated 18th July 2018 which stated the service showed adequate safety and made some recommendations for improvement. We contacted the fire authority who said work had progressed and they were continuing to follow-up with management.

We were provided with a service risk assessment, dated 17th July 2018. This addressed risks to staff including moving and positioning, and chemical hazards and a reference to "food poisoning" and "existing controls" of "good housekeeping and staff are up to date with training in basic food hygiene". There were no other references to systems in place for the prevention and control of infection. We were informed that the provider had a general Infection protection and control policy, but this was not provided to us to check. We were sent a compliance checklist for infection control, dated April 2011, and referred to the other service rather than procedures at Lavender Court. The home was clean including the kitchen cupboards and fridge/freezer, and we observed staff cleaning people's equipment. The home was free from odour and staff used protective equipment appropriately.

We recommend the service updates premises risk assessments and safety checks and ensures these are easily accessible within the service.

Good

Is the service effective?

Our findings

At the last inspection there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service was unable to demonstrate that staff received appropriate training, supervision, support or performance reviews. At this inspection there were improvements and the service was no longer in breach of this Regulation.

The service was in the process of developing a training tracker during our inspection visit. We were provided with a training matrix electronically after the inspection which contained significant gaps, however there was a time specific plan for the service to improve this. Staff told us that training opportunities had improved, and they had attended some training and were booked upon others. We found that no staff were up to date with mental capacity training and the majority had never completed this training. Three out of 17 staff had completed safeguarding in the past three years and nine staff had never completed this training. The registered manager had completed safeguarding training at a level proportionate to their role, however this was also out of date. This was not in line with the provider's training pathway and meant staff were not suitably trained. Staff were required to complete medication training and we saw completed annual competency assessments for most staff including regular agency care workers. Three staff member's medication training had expired, and one had not received a competency assessment for over two years. We saw that training was arranged for the following month. We were given information after the inspection that all staff had now completed online training in fire safety, infection control, safeguarding level one, and first aid and administration of medication for those who were out of date. There were further timely plans for staff to complete Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DOLS) training, risk assessment and behavioural management training.

Staff were expected to complete online training when there were quiet moments in the home. This resulted in staff not having opportunities to complete this with comments such as "we have told them we need more time allocated for e-learning", and "it's difficult for staff to do on line learning in the home." Computers for online training were situated in the staff office and staff said it was difficult to concentrate with work going on around them. Management told us they would look into covering staff on shift to ensure staff ratios were not impacted and enable staff sufficient time. This would allow staff to leave the building and access computer facilities in the adjacent day centre, or the manager's office when the other service opened. We were told there was a plan to access a laptop for staff and management.

We checked staff supervision records and noted that staff had not received regular supervision in the last 12 months. The service had developed a supervision matrix and had started to plan supervisions. There had been a concerted effort by management to complete appraisals which was achieved for most staff. Some staff had received supervision more recently and others were planned. Senior staff were also responsible for undertaking care worker supervisions, however we noted that seniors and their supervisees were not rostered at the same time. Furthermore, senior staff received 6 hours per week to complete administrative duties which we were told was not sufficient to achieve supervisions. One staff member told us they had been denied supervisions when they have asked for one due to a lack of process or time but said this had improved recently.

We recommend the service sustains appropriate staff training and supervision and implements a robust system to monitor this.

The service referred people to relevant healthcare services appropriately, such as the mental health team, occupational therapy (OT), dietitian, and psychiatry. We found that people received timely support with their health and wellbeing needs although health actions plans needed updating. We were provided with one person's hospital passport after the inspection which included clear information and addressed needs holistically. A relative told us they had been consulted and involved in their relative's health care needs. The service was proactive in accessing the right treatment for the person and co-ordinated clinicians to visit people at home where there were barriers to accessing community services. We were told analysis and behaviour forms were completed and shared with the relevant people and informed the person's positive behaviour guidelines. These records were not in the person's care file, but we saw they were referenced in the community team's documentation.

The service did not use the Malnutrition Universal Screening Tool (MUST) to identify people who were malnourished or at risk of malnutrition (under nutrition), or obesity. We saw that the dietitian was involved in people's care where there was a need and the service followed nutritional guidance. Weight records were recorded electronically; we observed two people's weight records which were not completed in accordance with the agreed frequency. Staff told us that the dietitian checked people's weight when they visited approximately every three months, however there was not a reliable method to monitor people in between visits. We noted that instructions in one person's speech and language therapy (SALT) swallowing guidelines had a line through it, which was not signed or dated. Staff demonstrated they were aware of this change. The registered manager told us that SALT had recently reviewed the person and a change had been made, however they had not received the updated guidelines. This was looked into immediately by staff and we saw the updated guidelines the following day.

We observed that menu plans did not include a second choice. Staff explained that people chose their own menus options in residents' meetings, and alternatives were offered if an individual changed their mind. One staff member said they had raised with management that a second choice should be planned on the menu, but this had not been taken forward. We saw that a variety of drinks and snacks were available and easily accessible. Staff were responsive where people required support to make a choice of snack. Staff reported that there was some confusion about what snacks should be offered for supper and whether this was in accordance with dietitian plans. We observed appropriate equipment, such as plate guards and adapted cups which were used for individuals to promote independence when eating.

We recommend the service implements MUST and records people's weight, and ensures menus choices are developed in line with best practice.

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

We saw documentation about mental capacity best interest that was completed by healthcare professional for dental intervention, which involved the person's family member. People's care plans included whether they had capacity to consent, however there was no documented assessment to support this. Neither did

the service have a capacity assessment or best interest template to aid this process. In general staff we spoke to demonstrated knowledge of mental capacity and best interest principles, and we saw good evidence of staff seeking people's permission during the inspection visit. During our visit the service was arranging for people to access flu vaccinations and we were told capacity assessments and best interest decisions would be completed in collaboration with the nurse.

We recommend the service implements MCA documentation where it is responsible for leading specific decisions.

We observed staff complete a thorough, person centred handover which aided the co-ordination of people's care and support. Staff told us they attended staff meetings and said they were an "open forum" where they could contribute. We looked at records and could see that staff meetings were regular and addressed changes in people's needs. The mental health team had also attended staff meetings to talk through a person's care plan and deliver proactive support strategies training.

The premises had recently undergone extensive refurbishment work to improve the suitability and comfort for people living there. Relatives commented "I'm impressed with the works for [family member]", and "there have been a lot of improvements – showers, en-suites. I'm really pleased with that." Assisted baths and over-head tracking was available for people who needed support with transfers. There was ample communal space for people to socialise or move to another space away from people. One care worker said, "everyone has shown they are happy with their bedrooms, there were more opportunities for the home to be more personalised now, and we've noticed people are more sociable." People's private spaces had been personalised in accordance with their tastes and interests; one person appeared very proud of their room and initiated communication about it, showing us the furnishings and colours. Decoration was sparse in other areas as the registered manager was still waiting for some furniture deliveries. The garden was not in use and external doors were locked to prevent unsupervised access. There were plans to landscape the garden to improve access for people with mobility difficulties by the new year.

Good

Is the service caring?

Our findings

In general, we observed staff treated people with kindness and respect. Relatives fed back that staff treated their family members well with comments such as, "[Family member] is well looked after, and respected nicely", "staff are very kind and caring in everything, they take time to help [family member] with her appearance which is important to [the person]" and, "staff are patient, caring and kind." Relatives also commented they felt welcomed when they visited their family member; "I can visit any time and feel really welcome." And "staff make me feel welcomed when I visit and offer me tea or dinner". The service had strong contacts with advocacy services. Four people received support from advocates and we observed an advocate visit a person in their home in relation to decisions about their care and treatment.

On two occasions we heard staff address people using inappropriate terms albeit in a warm and friendly manner. People could not verbally tell us how they preferred to be addressed or how they felt about these terms. We raised this with the registered manager who acknowledged such terms of address were inappropriate and that this would be raised with individual staff, and values of respect and dignity reinforced with the staff team.

People were consulted with and informed about visitors to the service. Staff were seen to treat the environment respectfully as people's home and took noticeable care to not encroach upon their private or communal spaces. The premises had been designed to improve people's privacy and dignity by adding en-suite bathrooms. Staff protected people's privacy by ensuring bedroom and bathroom doors were closed and supporting people with personal care discretely. We saw that a person's access to their room key was addressed in their care plan with the aim to promote privacy and independence. One person had a listening device in their room at night, so staff could monitor for epileptic seizures. The registered manager said an epilepsy sensor had been ruled out as the person's epilepsy was well controlled. We discussed whether a sensor could achieve greater privacy, without staff listening constantly throughout the night, which the registered manager said could be considered. One member of staff said that the registered manager promoted a values-based approach with the staff team, and commented they were "pro service users' rights and ensured that staff consulted with people. Recently [the registered manager] reminded staff to only open people's mail with their involvement."

We observed staff treat people with warmth and they adapted their approach to engage and involve people in activities. For example, we observed one care worker singing a person's favourite song to encourage a their involvement in choosing and preparing their preferred drink. We saw a person initiate verbal communication which was difficult to understand, the care worker repeated the phrase back to check that was what the person had said. The person smiled and showed the care worker their drawing who said, "that's beautiful", which appeared to make the person very happy. On another occasion we saw staff notice that a person's glasses had slipped down their nose and offered to assist the person, who agreed.

Staff showed concern for people and worked proactively to respond to individual's needs. We observed staff were meticulous in describing people's physical and emotional well-being during a handover meeting. Staff were concerned they hadn't received a call from the clinician that day about a person's planned blood test

in the home; staff quickly arranged to call the doctors surgery to follow-this up. Staff spoke about people respectfully and used positive language to describe people's mood-states. One person was described as 'very active and in a lovely engaging mood' which staff were pleased about. Staff were aware that meant the person was more likely to try and gain access to people in their rooms. Staff co-ordinated with each other to be especially vigilant of this and implement the agreed strategies of distracting the person through meaningful engagement, and to encourage people to keep their bedroom doors shut. We were told this was a successful method in protecting others' privacy. Staff told us they felt there were currently sufficient staff to provide personalised care although they were concerned this would change for the worse if staffing levels decreased with the opening of the new service.

We observed staff respect and promote people's independence. For example, staff ensured they emptied the kettle and turned off electrical appliances in the kitchen. This was an agreed safe measure to reduce hazards and promote people's kitchen access and independence. We saw that this was particularly important to one person who visibly enjoyed spending time in the 'hub' of the home and was empowered to initiate the support they wanted to access snacks and drinks.

Confidentiality in the home was maintained. People's records were locked away in cupboards in the staff office, which had a key pad entry system and was kept shut when not in use. Staff handovers and people's documentation was completed in the staff office. Electronic records were only accessible with authorised user log-in and passwords. Staff records were currently locked away in the day centre manager's office until the new service (with manager's office) was opened, and until another cabinet was delivered to Lavender Court.

Good

Is the service responsive?

Our findings

The service ensured people's wishes and preferences were identified and included in people's care and treatment. People were unable to tell us whether they were involved, and individual's communication difficulties meant management and staff needed to use creative methods to involve people. We saw this evidenced in people's care plans. For example, a specific NHS template was used to understand and document what was important to the person and interpreted the function of certain behaviours and gestures. Staff facilitated residents' meetings weekly. This was recorded, and we saw that people's responses were listened to and responded to. For example, people contributed to the menu and agreed what events and activities they wanted to do.

Relatives told us they were involved in their family member's care and treatment. One relative said they were contacted by staff once a week with an update of the person's well-being. Another relative said "I recall being asked to be the person's representative for an assessment. They will always ask for my involvement and ask my opinion" and "staff give me updates – doctor a couple of weeks ago for a medication assessment and told me about the flu vaccine". We saw that a person's relatives were identified to be involved with their Deprivation of Liberty Safeguard (DoLS) assessment. We also saw evidence that relatives were consulted with about medical treatment and best interest decisions. Where people did not have a family representative, advocates were involved and contributed to planning care and support.

Care plans were up to date, comprehensive and person-centred. They included details of the person's history and preferences and included religious and cultural needs. Care plans went into detail about people's abilities and strategies to promote their independence. People did not always receive a co-ordinated review of their care and treatment. The registered manager told us that most people did not have an allocated social worker and reviewing officers did not attended reviews. Where reviews had taken place, the reviewing officer had not provided a copy of the review to the person. The registered manager said he would follow this up as people had a right to a copy of these records. It was also necessary for the service to keep this type of documentation to co-ordinate up to date care and support as well as agreed actions.

We recommend the service completes their own records for people's reviews in line with best practice.

The Accessible Information Standard (AIS) 2016 is a framework put in place making it a legal requirement for all providers to ensure people with a disability, impairment or sensory loss can access and understand information they are given. People must have the information necessary to make decisions about their health and wellbeing, as well as their care and treatment, and to access services.

Care plans clearly documented how people communicated and included an interpretation of the function of gestures and behaviours. We saw that people's communication methods were included in their hospital passport to ensure this was shared with relevant hospital staff as required. Staff interpreted people's body language, gestures and vocalisations and understood the function of people's communication and behaviour. For example, one person who could not verbally communicate showed that they wanted to move on to another activity through a certain gesture, which staff recognised and responded to quickly.

Staff referred to using picture cards and Makaton (sign language) however we did not observe staff use these methods and were told this was work in progress. The service did not provide specific communication training, although some longer standing staff had accessed Makaton training in the past. There were clear visual pictorial references and 'easy read' text around the home about topics relevant to people. For example, there was a display about an upcoming party, and the photo board for staff on shift that day was up to date. Staff explained that they were using a trial and error approach to the photo board to find out what was most accessible to people. This demonstrated that staff were open to adapting communication methods to include people as much as possible.

We recommend staff are provided with communication training which is specific to people's individual needs.

At the last inspection there was a breach of Regulation 9 of the Health and Social Care Act (regulated Activities) Regulations 2014. This was because people were not provided with satisfactory activities or opportunities to follow their interests or socialise. At this inspection we found access to opportunities had improved. Staff told us that because the number of staff had increased they were able to support people to engage with more activities in the community. During our visit we observed that staff engaged people in meaningful activities within the home and supported people to access the community. We checked people's "activity planner" which included a variety of individual leisure and therapeutic activities at home and in the community. We noted that at weekends the activity planner provided less structure and stated "group" activities, without defining what this was. However, we were aware of events that people planned to attend over the weekend. Staff and relatives were concerned if the current staff numbers were not maintained this would have a detrimental impact upon their family member's emotional and physical well-being. Another relative told us their family member was currently supported to access activities, but they were concerned about the future; "I am pulling my hair out trying to progress things and secure future staffing for activities. The issue seems to be funding and a lack of staff drivers at the service." One staff member told us that they had put themselves forward to become an additional driver, and the registered manager confirmed they were arranging training for more drivers.

Relatives told us they knew who to escalate any complaints to and how to contact the management of the service. There was a complaints process in place and a means of recording complaints. The service had a complaints leaflet that included details of how and when people could expect a response to complaints. There was a "resident complaint form" in an easy read format, however we were told that people did not currently have the ability to complain. We saw documentation of a received complaint from a relative and a log of management's response and outcome.

At the time of the inspection no one was being supported at the end of their life, however we saw documented end of life plans that included people's preferences, where known, and detailed which relatives wanted to be consulted with. The registered manager had received training and confirmed that specific training was available for staff if this was required to meet people's needs.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection the service was in breach of Regulation 12 (Schedule 3), 15 and 18 of the Care Quality Commission (Registration) Regulations 2009. There was also a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found improvements and the service was no longer in breach of Regulations 12, 15 or 18. However there was a repeated breach of Regulation 17. This was because no evidence could be produced that the service effectively assessed, monitored or improved the quality and safety of the care provided. We also found that the service and people's records and documentation were not always accurate or updated.

A service check list was recently developed and delegated to one of the senior staff. The registered manager said they did not currently have oversight of the audits although they planned to follow this up in staff supervision in the future. The items listed did not comprehensively cover the quality or safety of the service and the senior staff member was not provided with guidance about the scope or frequency of checks. Neither were there any themes or trends identified for improvement. There was no system to follow-up or document outcomes of internal or external audits or who was responsible; the registered manager did not use a service improvement plan. We checked a pharmacy audit dated 3 April 2018 which listed numerous recommendations, but management could not tell us whether these had been addressed and when we checked for ourselves we found recommendations had not been implemented. For example, we found an old medication policy in the medicines cabinet, which was identified in the pharmacy audit with a recommendation this should be removed. Another recommendation addressed differences in the two service's medicines documentation system which caused staff confusion. The pharmacist recommended that "ideally you have a single system that ensure safe and accurate medicine management…" The manager told us they decided this was not practical because people in the other service provided their own medications. This decision had not been recorded on a risk assessment and did not explain why the same administration documentation could not be used. Staff told us they continued to be concerned that a lack of consistency would lead to medicines errors. There was not a provider process that enabled oversight or scrutiny at board level of the monitoring systems in the service.

Some service health and safety and people's records could not be found during our inspection visit. The registered manager said that some records were in storage but could not recall what was there and did not have a recorded list to refer to. We received some documentation electronically after out inspection visit, however the legionella risk assessment, dated August 2015, was out of date and did not accurately reflect the premises since the refurbishment in 2018. The registered manager told us that identified actions had been addressed, but there was no documentation to support this. There was no system in place to check that staff had read and understood service policies and procedures. The registered manager could not provide us with a list of these but said that some policies could be accessed on the local authority's website, however staff told us they did not know where to access them. Long standing members of staff recalled they read and signed policies and procedures "a couple of years ago" but did not know where these records were held.

Relatives said they received regular surveys but were not always told about the outcome. We found there

was no system in place to monitor trends or provide feedback about outcomes to relatives. There was a service user survey template, but these had not been completed.

We looked at documentation related to organisational learning from accidents and incidents. Records were only available for 2018. We saw the manager had reviewed and analysed information, however when we spoke with staff they told us they were not aware of outcomes. The service did not use a specific process or template to document investigation findings and outcomes which meant that learning from incidents was not optimised.

This was a breach of Regulation 17 of the Health and Social Care (Regulated Activities) Regulations 2014.

At the last inspection there was a breach of Regulation 12 (Schedule 3), because the service had failed to submit a statement of purpose (SoP) to us. This is a legally required document that includes a standard set of information about the provider's service. At this inspection we found the service still had not updated and submitted the SoP in accordance with requirements. We brought this to the attention of the registered manager who submitted the SoP after the inspection visit. The breach of Regulation 15 at the last inspection was because the service had failed to notify us of necessary changes or events at Lavender Court. At this inspection we found an improvement as management had notified us of the service being dormant and reopening on completion of refurbishment work. The breach of Regulation 18 (Registration) regulations was because the service had failed to notify us of Deprivation of Liberty Safeguards (DoLS) authorisations. At this inspection we found that the service still had not notified us. This was rectified swiftly and notifications were submitted during our inspection visit. This meant the service was no longer in breach of this Regulation 18 (Registration) regulations.

We looked at the culture and leadership of the service. There was also some confusion about the vision for the service. Relatives and other stakeholders had been told the home would become a supported living service. One relative told us they had not been updated about this and we saw that external reports referred to the service as supported living. We raised this with the registered manager who said this had been a previous plan but was not going ahead due to people's needs and care packages.

Staff told us that the registered manager was not based in the service day-to-day but was contactable and would always phone the service to check upon people's well-being. Most staff we spoke to said they felt supported by the manager more recently and enjoyed their job. The registered manager confirmed that they were usually based in an office away from the service and they were busy overseeing the building project for the other service. A relative said "[the registered manager] has been very helpful over the years but is not so hands on now. [The registered manager] has taken on too much looking after both services. Somebody has to say - is overwhelmed and this impacts on their ability to manage the service. They are in constant demand from the builders. Needs a full time assistant manager to support the home." Another relative said "there is no management oversight."

Staff reported that a minority of colleagues did not work collaboratively as part of the team and were still resistant to management. The two senior staff were experienced as care workers and were developing in their roles as seniors since the restructure. They showed commitment to improving systems in the service. The seniors were allocated one shift per week for administrative duties and to supervise the staff team, but even during this 'protected' time were required to provide guidance and direction to care workers in the absence of the manager. This meant that it was difficult to accomplish their 'management' duties including the update of records and supervision of staff. It also meant there was not sufficient management oversight to address issues and provide direction to the staff team day-to-day. We discussed this with the registered manager and operations manager who agreed that there needed to be support from the provider to enable

the registered manager to base themselves in the service regularly.

Equality and diversity training was available, however, only one member of staff had completed this at the time of the inspection. Staff demonstrated that they respected people's rights and diverse identities but were not familiar with specific protected characteristics. Staff worked hard to ensure people were able to access healthcare and other services to meet cultural needs in the community.

The registered manager described that staff working relations and co-operation after previous changes to the staffing and management structure, had improved since our last visit. However, they were aware that some staff continued to be concerned about how working across both services would affect working conditions. Staff also told us they were worried about continuity of care for people. The service was providing consultations with staff and we saw that information was provided and discussions were facilitated at team meetings.

There was a registered manager in post which met the conditions of the provider's registration. The management were familiar with the duty of candour regulation. This requirement ensures that providers are open and transparent and provide information and an apology when things go wrong with care and treatment.

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 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 People's care and treatment was put at risk due to inaccurate and out of date information in their individual risk assessments. Hazards and measures to mitigate risk were not always identified or documented in individual's risk assessments. Service safety checks were not always followed-up or documented. We saw there was an in-date electrical wiring test certificate with remedial actions identified. We were told these had been completed by the maintenance contractor, however there was no audit trail for us to check. There was a legionella prevention monitoring system, but records were missing from the log book. This was not in line with the provider's "Legionella Risk Management Guidance", which said records were held on site and must be easily accessible at all times. We asked for records to be sent to us after the inspection and received sampling and treatment records up to December 2017. We could not check whether sampling or appropriate actions required by the provider had been completed since then.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Service documentation and people's records were not always accurate, up-to-date or available. Paper copies of policies and procedures were not available. The RM thought that some might be in storage but could not access these. We were told the service followed

Slough Borough Council's policies and procedures but the service did not provide staff with a list of what was relevant or what they were expected to read and understand to perform their role. There was no staff read and sign documentation for policies and procedures. Some health and safety records were not available i.e. Legionella and other maintenance remedial works for electrical wiring. There were not satisfactory systems by the registered manager or the provider to effectively assess, monitor, evaluate or improve the quality and safety of the care provided. There was a recently created check list that was delegated to the assistant manager, but this was not comprehensive and they were not provided with guidance about the frequency or scope of checks. The RM did not have oversight of these and did not use a service improvement plan. There was no record of identified actions or progress.