Quality Care UK Limited

Lavender House

Inspection report

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Date of inspection visit:
31 July 2018

Date of publication:
10 October 2018

Ratings

Overall rating for this service	Inadequate ●

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

Summary of findings

Overall summary

Lavender House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide personal care and accommodation for up to 32 older people, including those with dementia related conditions. It is located in Brough, in East Yorkshire. At the time of our inspection there were 20 people living at the service.

This inspection took place on 31 July 2018 and was unannounced.

At the last inspection in June 2017 we rated this service 'requires improvement'. We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were regulation 15 (premises and equipment) and regulation 17 (good governance). These were continued breaches from a previous inspection in April 2016. During this inspection we have identified continued breaches in regulation 15 and 17 and identified new breaches in regulations 9 (person-centred care), 10 (dignity and respect), 11 (need for consent), 12 (safe care and treatment) and 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also identified a breach of Regulation 18 (notifications) of the Care Quality Commission (Registration) Regulations 2009. This is the third-time breaches of regulation 15 and 17 have been identified and the overall rating of this service is 'Inadequate'.

The service is required to have a registered manager in post. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection there was no registered manager in place. We met with a newly appointed acting manager and the registered provider during the inspection.

Maintenance of the building was poor and not completed in a timely manner. A garden area for people to access was unsafe; building materials, rubbish and broken equipment surrounded the service and created a risk to people, staff and visitors to the service. Ceilings were stained and a bathroom had tiles missing on walls. People were left with broken lights, toilets and window chains for weeks before repairs were completed.

Infection control measures continued to be insufficient to prevent the risk of inspections spreading. Bathroom floors were not sealed at the edges to allow adequate cleaning. We found dust and dirt throughout the building. This is the third consecutive time infection control concerns have been raised with the provider during an inspection.

The systems which the provider had in place to assess the experience of people receiving care had not identified the extent of concerns we observed during our inspection. There had been a failure to rectify the failings identified during our last two inspections and this meant people received inadequate care and

support in line with our regulations.

Measures required to reduce the risk of harm to people were in place but they were not always completed accurately or were up-to-date. Medicines procedures and systems were in place; however, some improvement was required to ensure medicine practices were safe.

People's care plan reviews were not always effective at recognising a change in people's needs. Relatives told us they had not been invited to be part of reviews. As a result, care plans failed to reflect people's person-centred needs. Daily notes were found to be repetitive and failed to accurately reflect how care was provided in line with the person's care plan.

Some interaction with people using the service was observed to be 'task' focused. The staff were very busy during the inspection and the newly appointed manager was still delivering care. This had impacted on people's dignity. People felt the provision of activities could be improved to meet the wider needs of people.

The provider failed to understand their duty under the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and were depriving people of their liberty without the legal authorisation to do so.

The provider had failed to notify CQC of all incidents within the service. We are looking at this matter outside of the inspection process.

Recruitment processes were in place. Staff had received training which provided them with the skills to meet the needs of the people. Staff had an understanding of how to safeguard people from abuse. Records of incidents and accidents were maintained. People's nutrition and hydration needs were catered for and the meal time experience was observed to be calm.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate enforcement action, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The premises and equipment were poorly maintained. Carpets, flooring and furniture required replacing.

Areas of the service posed a risk of infection. Dust and dirt was found around the service.

Outside of the building, including a designated garden area for people, was not safe.

Risk management plans were not always up-to-date to reflect people's current risks.

Medication processes needed to be more robust.

Is the service effective?

Requires Improvement

The service was not always effective.

The premises failed to meet the needs of people who used the service.

Staff had not been provided with regular supervision or an annual appraisal to support them in their role.

The provider failed to act in line with the MCA and appropriate authorisation was not sought. People with capacity were not always asked to provide written consent to their care.

Is the service caring?

Requires Improvement

The service was not always caring.

Some interaction with people was 'task' focused. The new manager had not been provided with management hours and was still delivering care.

People's dignity had been compromised through a poor environment, delays in repairs and lack of staff time to meet people's wider needs.

Relatives were made to feel welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had care plans in place but reviews failed to reflect changes in people's needs and daily recording did not reflect the care described in the plans.

The provision of meaningful activities could be improved to meet the wider needs of people.

There was a complaints policy and procedure in place.

Is the service well-led?

Inadequate

The service was not well-led.

Governance systems for assessing and monitoring the quality of the service were in place. However, they were not robust enough to identify all concerns or address actions in a timely manner.

There was no registered manager at the service. The provider had not notified CQC of all incidents in the service.

The action plan agreed following the last inspection to drive forward improvements had not been implemented.

Lavender House

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 checked 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 was a comprehensive inspection that took place 31 July 2018 and was unannounced. The inspection team consisted of one inspector and one assistant inspector.

Before the inspection we reviewed the information, we held about the service, such as information we had received from the local authority and notifications we had received from the provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service.

During the inspection, we observed how staff interacted with people who used the service throughout the day and at meal times. We spoke with five people who lived at the service, three care assistants, one chef, two family members/visitors, the acting manager, the registered provider and one visiting professional. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at three care files which belonged to people who used the service. We also looked at other important documentation relating to people, such as medication administration records (MARs) and monitoring charts for food, fluid intake, weights and pressure relief.

We looked at a selection of documentation relating to the management and running of the service. This included three staff recruitment files, training records, the staff rota, minutes of meetings, quality assurance audits, complaints management and maintenance of equipment records. We completed a tour of the environment.

Inadequate

Is the service safe?

Our findings

At our last inspection in June 2017, we rated the safe domain as 'requires improvement'. During that inspection we had identified a number of ongoing concerns from the previous inspection in April 2016, in relation to the maintenance and cleanliness of the building. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we have identified a continued breach in regulation 15, this is the third time that a breach in regulation 15 has been identified. We have rated the safe domain as 'Inadequate' for this inspection.

We were previously concerned the garden was not safe and secure for people living with dementia to access the space independently. Although the provider had taken action to secure the perimeter of an area of the garden, people were still not safe to access this space independently. Staff advised us people would only access the garden with staff support 'at all times'. We saw that the garden area was unmaintained, the surface was uneven with holes and broken items such as, plant pots and wood were laid at the edge of the garden.

On the day of the inspection people were able to access the outside of the property through the laundry, as there was no lock on the laundry door and the back door had been left open all day. This outside space was not safe for people. There were broken items such as equipment and building materials at the front, side and rear of the building which were unsafe and posed a risk to people, staff and visitors to the service. We identified items at the rear of the property including a broken washing machine and a trailer of broken items that were on the immediate grounds of the property and posed a serious risk to people falling or injuring themselves. We raised this with the provider who advised that the back door should be kept locked at all times to prevent access for people to this area.

We found the service's premises and equipment were poorly maintained. We saw flooring and carpets needed replacing, stained ceilings and tiles were missing from bathroom walls. Bath chairs and the weight chair were in poor condition and required replacing. Although the light bulbs in the small lounge worked, every light fitting was broken with glass damaged or missing.

This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified several infection control concerns as part of this inspection. For example, we saw the laundry area was unclean and unorganised, the flooring and hand washing facilities were dirty. Clean clothes were stored near dirty areas, non-laundry items and broken equipment. As we looked around the service we saw there were areas of concern regarding cleanliness. Dust and dirty floors were identified throughout, radiators particularly were filthy. There were a number of malodours that were not managed by the service, a bath seat was dirty and we saw dirty toilet seats. Flooring in all communal bathrooms and toilets were not sealed at the edges so effective cleaning could not take place. We communicated this to the registered provider who took action to address the flooring concern during the inspection. We asked to look at cleaning schedules but the provider stated none were in place.

A number of risk assessments were in place for people, these included; falls risk, moving and handling and nutritional risk assessments. However, not all assessments were accurate. We found one risk assessment was out of date which misrepresented a person's level of mobility, describing them as more mobile than they were. This created the risk that staff would not deliver appropriate support for this person when mobilising. A person whose skin was at risk of pressure damage, had a waterlow risk assessment in place that had not been completed accurately and identified them at a lower level of risk. This put them at risk of not receiving the right care and support to help manage this risk.

Risks to people in the event of a fire had been considered. Each person had a personal emergency evacuation plan (PEEP) in place. We identified one person's PEEP that failed to correctly record the assistance they would need to evacuate the premises. This meant this person was extremely vulnerable in the event of a fire as the PEEP failed to identify how this person could be safely removed from the building.

We looked at the systems in place to manage people's medicines. We found there were regular gaps in the recording of the application of all prescribed creams. This meant the provider could not ensure that medicated creams had been given as prescribed. Protocols were in place for medicines required when needed. Some protocols needed more detail to enable staff to be clear when medicine was required. Although staff received training in medicine administration, they had not had their competency checked to ensure their learning was embedded in their practice. We observed a member of staff administering people's medicines and they demonstrated competence in this.

We saw disposable gloves were easily accessible by people which posed a potential risk of ingestion to people who used the service

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the recruitment records for three members of staff. These evidenced that a Disclosure and Barring Service (DBS) check was in place prior to applicants commencing work. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults.

Staff were observed to be very busy during the inspection. The newly appointed acting manager had not been allocated any managerial hours and therefore still provided care and support to people during every shift. This impacted on the rest of the care staff when the acting manager needed to address managerial tasks such as locating information and records. We observed people had their basic needs met during the inspection, however, staff were task focused and had no time to meet the wider needs of people. The provider told us they were present at the service on a daily basis to provide additional management support.

Safeguarding and whistleblowing policies were in place at the service and staff we spoke with demonstrated knowledge of what to do if they had concerns. The registered provider advised us there was no manager's log of safeguarding incidents within the service as they had not had any. We checked this with the local safeguarding authority who advised they had one record for this year and this had been resolved.

The registered provider had systems and processes in place to record accidents and incidents. We found there had been limited accidents recorded in the service since our last inspection. Where accidents had been recorded this included a record of actions taken.

Where people had been identified as at risk of skin pressure damage we saw air mattresses were in use for them. We saw that some people had bed rails and basic risk assessments were in place to ensure that the risks were managed safely. Audit checks were in place to record routine checks on bed rails, however, these needed to be reintroduced since the registered manager had left.

Maintenance records showed that safety checks and servicing had been completed on the gas supply system, the passenger lift and the electrical installation. Some documents could not be located during the inspection and we requested these to be provided after the inspection. Although some information was received, they failed to provide all the requested information.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we rated effective as 'requires improvement'. We identified during the last inspection in June 2017 that previous concerns from our inspection in April 2016, about the maintenance of the service, had not been met and we found the service was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we have found a continued breach in regulation 15 and as the required improvements had not been made this domain continues to be rated 'requires improvement'.

As we looked around the service we still had some concerns that the environment did not support the needs of people living with dementia. Disorientation and bewilderment are a common experience for people with dementia. Signs can be very helpful if they are clear, mounted low enough, have words and a picture and contrast with the background. Since the last inspection the provider had introduced the use of dementia friendly pictorial signs in some areas around the home. However, the same hand-written signs identified in the last inspection report as being confusing, were being used in the communal lounge and upstairs. The action plans created by the previous registered manager, in response to our inspection in June 2017, stated they would consider making people's bedrooms easier to locate through painting doors and door frames contrasting colours and using pictures on people's doors. This action plan had not been implemented. Bedroom doors had not been painted, they were not consistently numbered or displayed people's names on them.

This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans we reviewed identified people's capacity to make decisions under the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack 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. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that although care plans reflected the principles of the MCA, the service and the registered provider failed to understand their duty under the MCA and were depriving people of their liberty without the legal authorisation to do so. We were advised by care staff that three people in the service had a DoLS in place. On checking the paperwork, we identified one DoLS had expired in June 2018 and another application had not been submitted. Another person's care plan clearly identified that a DoLS application required submitting, but the provider advised us this has not happened. We found another person's DoLS had expired in June 2017. The registered provider advised us that they had made the decision not to reapply for this person's DoLS as they felt that the person didn't meet the criteria any longer. This decision was not made with other relevant stakeholders and recorded as a best interest's decision. The only record of the decision were notes written on the back of the original application, that were not signed or dated. Based on

the information we read in the person's file, it was clear this person did require a DoLS to be in place. People who lacked capacity and had bed rails in place to keep them safe, did not have a best interest decision in place to authorise this restriction. Some areas of the care plan were not signed by people to provide consent where they had capacity to do so.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that staff supervision meetings had not been held on a regular basis. Within the last eight months most staff had received only one supervision. Where supervisions had taken place, records showed that these were of poor quality, recording the same standard statement for each person. Supervision meetings give staff the opportunity to discuss any concerns they might have, as well as their development needs. There were no records of any annual appraisals. Staff we spoke with told us they felt supported by management but they hadn't received supervision.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training which provided them with the skills to meet the needs of the people. On speaking to staff, they told us they were happy with the training provided, "The training is good, we do courses every year, it's face to face training at the service and the trainer is good." A copy of the services training matrix was provided and recorded some staff's attendance on courses including; understanding dementia and skin and pressure care.

New staff completed an induction when they started working at the service which was recorded in an induction checklist. Not all checklists were available in files for us to review, however, staff told us they completed an induction when they started.

We observed the dining room experience during the inspection. We observed people choosing where they wanted to eat their meal, either in the lounge, dining room or their bedroom. People were asked and encouraged to choose what they wanted to eat however, there was no pictorial menu displayed and people with dementia were not shown food options. Where people required assistance from staff to eat and drink, this was provided in a way that met people's needs. People who used the service gave positive feedback about the food they received. Their comments included, "The food is excellent, I have never had a bad meal yet."

Records showed a range of healthcare professionals were involved in the care and treatment of people who used the service. Health care professionals confirmed they had good working relationships with the service. Comments from them included, "We are always welcomed by the staff when we arrive and they tell us anything we need to know straight away."

Requires Improvement

Is the service caring?

Our findings

Although we observed staff were very caring in their interactions with people we also observed that they were 'task' focused at times and this had impacted on people's dignity. Staff were observed to be very busy during the shift. The newly appointed acting manager had not been removed from the rota, so they were undertaking managerial tasks as well as continuing to provide direct care to people. The acting manager advised us the intention was to remove them from the rota but the provider was in the process of recruiting more care staff to cover their post. Although people's basic needs were met during the inspection, staff did not have time to focus on people's wellbeing or sit and talk to people.

We spoke with staff about how they maintained people's dignity. Staff provided us with examples of how they respected people's dignity. Their responses included; "We make sure that we shut doors if we are helping people with personal care, we knock on doors before we enter, we make sure not to speak too loudly if asking someone if they need to go to the bathroom."

Whilst staff demonstrated knowledge of how to respect people, our observations did not always support this. We observed one person in the dining area who was sitting at the same table, on their own for the duration of the inspection. We completed a SOFI observation for a period of 40 minutes on this person, which recorded that there was minimal interaction from care staff throughout this time and no stimulation offered. We observed how staff's routines and 'tasks' took priority over respect and dignity for this person and their wellbeing. One relative told us, "If I am honest, there isn't enough staff. They work very hard but sometimes [person's name] has to wait for the toilet."

The poorly maintained environment evidenced a lack of respect or value for people living in the service. Some repairs were not completed in a timely manner which had impacted on people. Staff informed us of a broken toilet that had created terrible smells in a person's bedroom and in the corridors of the service. This was not fixed for a number of weeks. During the inspection we observed that only half of the light bulbs in the main lounge were in working order.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives spoke positively about the staff. Comments included, "Staff know [name of person] well. There are occasions like on a Friday it's fish and chip day and they know she doesn't like it so they do her something different." Another relative told us the best thing about the service was the friendliness of the staff, they said; "Nothing is too much trouble."

People told us, "Staff treat us with privacy and dignity, staff mostly knock before entering the room" and "Yes, they are very nice."

People's friends and relatives were welcome to visit, there were no restrictions to the amount of time they could spend at the service. Relatives we spoke with said, "I am made to feel welcome. I come often and they

let me come for lunch."

We discussed with the staff whether anyone had an advocate. Advocates provide independent support to help ensure that people's views and preferences are heard. Although no one at the time of the inspection had an advocate in place the staff demonstrated knowledge of the benefits of advocates.

People's cultural and religious needs were considered when care plans were being developed. Information about people's likes and dislikes and their religious beliefs was included within a life history document, informing staff all about their personal experiences and choices.

Requires Improvement

Is the service responsive?

Our findings

Reviews of care plans and risk assessments were recorded monthly. All of the reviews we observed recorded a standard statement confirming 'the care plan and risk assessment continued to meet the person's needs'. However, we found examples were the care plan and risk assessments did not meet the person's current needs, making the review process ineffective. For example, we found one person whose mobility care plan stated that they required the support of two staff at all times for transfers, however, the risk assessment stated this person was independently mobile. A care plan recorded a person's close friendships and relationships but had failed to be updated when this had changed a number of years ago. A care plan failed to reflect when the person's skin integrity had been compromised, with their care plan stating, 'my skin is currently in-tact' even though the person had a number of pressure sores since the care plan was written. Improvements were needed to ensure the review process was effective in ensuring that the care plan continued to reflect and meet the person's needs.

Relatives told us they hadn't been involved in people's reviews. They told us; "There hasn't been a review for a long while" and "No I am not really involved in the care plan or reviewing it."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans included information about people's individual needs, such as; personal support, mobility, physical health, sensory needs and medication. We found care plans respected people's ability to make their own choices. However, we found staff recording in daily notes to be repetitive and failed to accurately reflect how care was provided in line with the person's care plan.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Within the service there was a provision of activities, however most of the people we spoke with felt the provision could be improved. A poster was displayed within the communal lounge detailing afternoon activities to be provided within the home, these included regular quizzes. On the day of the inspection we observed a quiz taking place. We also observed records of monthly visits from external entertainers such as singers. Staff told us that the provision of activities needed to be improved. Comments included, "There are not as many activities as we would like, there is always a quiz a couple of times a week but that's about it. We would like to do more but we just don't have the time." There were no rummage boxes in communal areas and people did not have access to items which would distract them. A rummage box is a container filled with familiar items as a means of reminiscence. We also noted that no people were supported to access the outside space during the inspection which took place on a pleasant warm day.

Relatives told us, "I believe they sometimes have people in, they don't do a lot. I wish they could bring animals in and stuff like that" and "I don't think there's enough activities offered, they do a quiz and someone comes into sing to them. It could be better."

The provider had a complaints policy and procedure in place and this was on display within the service. One complaint had been received and these were recorded on a complaints log. The provider had dealt with the complaint received by conducting an investigation and responding to the complainant with an outcome. People we spoke with told us that they had never felt the need to complain, "I have never needed to complain, but if I did I would happily raise this with the manager." A relative told us, "I have never complained but would go to the provider. Since the manager has left nobody has spoken to us and said what the structure is going to be or who to complain to."

We observed the service had paperwork to be utilised to record people's end of life preferences. The training matrix showed a number of staff had received training in end of life care therefore staff were trained to facilitate discussions with people in this area.

Inadequate

Is the service well-led?

Our findings

At the last inspection in June 2017 we rated this domain 'requires improvement'. We had identified a breach in regulation 17 which had continued from the inspection in April 2016. During this inspection we found a continued breach in regulation 17. This was the third time the provider has been in breach of regulation 17 and we have rated this domain as 'Inadequate'.

Despite the service being rated as requires improvement at the last two comprehensive inspection's the provider had failed to deliver the required improvements to ensure people received care and treatment in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There had been a failure to rectify the failings identified during our last inspection demonstrating a lack of learning, reflective practice and service improvement.

Action plans created in response to our findings in our June 2017 inspection, to advise CQC of how the service was to improve, had failed to be implemented. A number of the same concerns identified during this inspection were highlighted and recorded in the provider's previous inspection report in June 2017. The provider had a lack of awareness of what was included in the last inspection report which demonstrated a lack commitment to meeting the regulations and provided no reassurances that they would meaningfully engage in a programme of improvements to meet our regulations.

Governance systems had not driven improvements as required. We found governance systems were not effective or robust and failed to drive improvements forward. Although the previous registered manager had recently completed some audits in the service these had failed to identify most of the concerns we had found during our inspection. For example, maintenance in people's bedrooms and communal lounges was delayed by weeks before being fixed, this included having working lights, toilets and safety mechanisms. None of these failings had been identified or followed up as part of an audit.

Where some concerns had been identified through audits, they had been escalated to the registered provider but no further action had been taken. For example, a recent audit identified a bath required fixing or replacing. Notes on the audit stated that this was shared with the registered provider who advised the bath could not be fixed and it was too expensive to replace. Another audit had requested that the provider removed the unsafe items at the back of the service, which the provider had not done.

The provider failed to have appropriate mechanisms in place to monitor compliance with MCA. The service was not meeting its requirements under MCA and there was no evidence of monitoring systems in place to identify or address this.

Care plan audits had failed to identify ineffective monthly reviews, that didn't capture people's change in needs, and inconsistencies in the documentation. Staff notes made in daily records were minimal, repetitive and failed to reflect care as described within people's care plans, yet this had not been identified by the manager or provider.

We found that although staff felt supported by the manager, the provider had failed to ensure staff had access to regular supervision and annual appraisals.

The provider had failed to effectively engage residents and relatives in the service provided. Relatives we spoke with advised that they had not been invited to any meetings to share their views and feedback about the service. The provider showed us one record of minutes of a relative's meeting which only introduced the new management structure. This was the only meeting recorded since the last inspection. After the inspection the provider advised us that 'Monthly residents meetings had been held up until June 2018 and that families and friends were aware of the open door policy Lavender House operates. The service offers a free period to see the Manger/Proprietor on a Thursday 2pm -4pm, however, anytime is made available.'"

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service in the form of a 'notification'. We identified one serious injury that should have been notified.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are looking at this matter outside of the inspection process.

The staff told us they felt supported by the provider. We saw two sets of staff meeting minutes for 2018 that discussed topics such as management cover, training, key working and laundry.

The service had built positive relationships with visiting professionals. Visiting professionals, we spoke with confirmed, "Some of the staff have been there for a long time, we know them well. The care is lovely."

The provider had no registered manager in post on the day of the inspection. The acting manager of the service had been in post three weeks but had not had any managerial hours allocated since starting this role.

Previous CQC inspection ratings were displayed within the service.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person-centred as they failed to reflect people's current needs and relatives and were not invited to be part of the care planning process.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff were task focused which compromised people's dignity. The environment did not demonstrate respect for dignity for people who use the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not submitted the necessary applications to deprive someone of their liberty in line with the MCA. Where people had capacity to consent to their care, consent was not recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Infection control systems were not in place to protect people from the risk of spread of infection. Risk assessments were not completed accurately or reviewed to reflect

	people's change in needs. Medication records for the application of creams was not sufficient to reassure the provider that it had been administered as prescribed. Protocols in place for medicines needed when necessary needed to be more robust.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The outside of the premises was unsafe. The service was poorly maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor the quality of the service provided had failed to identify most of the concerns we found during this inspection. Were actions had been identified these actions had not been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not supported through the provision of regular supervision or an annual appraisal.