Royal Mencap Society

Lawnswood Avenue

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 25 February 2016. Breaches of legal requirements were found including the cleanliness and maintenance of the home, the number of staff available to care for people and concerns that staff did not recognise the requirements for legal consent. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lawnswood Avenue on our website at www.cqc.org.uk

Lawnswood Avenue is registered to provide accommodation and personal care for up to eight people with varying learning disabilities. On the day of our inspection, there were seven people living in the home. There was a registered manager in post. 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.

There was a programme of on-going improvements being undertaken. A deep clean had been completed and repairs had been made to provide a safe and clean environment for people living in the home. The communal areas of the home were being decorated to improve the wellbeing of people and staff.

The number of staff available to care for people had been reviewed and amended to ensure they received the level of support they required when they were in the home and taking part in outdoor activities. Staff morale had improved and the level of staff support had increased.

People's ability to make their own decisions had been re-assessed. Capacity assessments which considered people's ability to consent to all aspects of their care and safety had been completed for most people.

We could not improve the rating for safe from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

We found that action had been taken to improve safety. Improvements had been made to the cleanliness and maintenance of the home. Staffing levels had been reviewed and increased to ensure people were supported adequately.

Is the service effective?

Requires Improvement

The service was not always effective. Applications to deprive people of their liberty had been made before some people's ability to consent to care and make decisions about their safety were assessed.

Lawnswood Avenue

Detailed findings

Background to this inspection

We undertook a focused inspection of Lawnswood Avenue on 29 September 2016. The inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 25 February 2016 had been made. We inspected the service against two of the five questions we ask about services: is the service safe and is the service effective? This is because the service was not meeting some legal requirements.

The inspection was undertaken by one inspector and was unannounced.

We spoke with three people who used the service, one relative, four members of the care staff and the registered manager. We spent time observing care in the communal areas of the home to see how staff interacted and supported people who used the service.

We also looked at the care plans for seven people to see if they accurately reflected the care people received.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we saw that some areas of the home were not clean and showed signs of disrepair. We found that the lack of maintenance was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the provider had followed their action plan in relation to the requirements of Regulation 15. When we arrived for our inspection, a programme of internal decoration was in progress. The registered manager told us that it had taken longer than anticipated to clarify whether the responsibility for decoration lay with the landlord or with the provider. Once this had been sorted out, decoration by the landlord had commenced.

We saw that the home had been deep cleaned and the paths leading to the property had been repaired to reduce the risk of people falling because on uneven surfaces. At our previous inspection there was only one fully functioning bathroom which meant there were insufficient facilities for everyone living in the home. We saw that the bath had been repaired and the cracked backrest, which had been a potential source of cross infection, had been replaced. This meant the provider had taken action to improve the environment for people living in the home.

At our last inspection we also found that at times there were insufficient staff to meet people's needs. We judged that this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On this inspection we found there had been a review of staffing levels and recruitment. Staff told us the home was fully staffed and the number of staff working at night had been increased. A person told us, "Staff come when I call them at night". A relative said, "The staff are absolutely superb, they're extraordinary". One member of staff told us, "Staffing is better, we have two waking staff at night now. Staff are less stressed". Another member of staff said, "There's been an improvement. We have new staff and can spend more time with people". We saw that there was advance planning of the staffing levels to ensure people were supported to take part in their external pastimes and activities. A member of staff told us, "Staff are happy to pick up extra. The manager and the deputy will work with us as well to help out". The registered manager told us, "We are recruiting some relief staff to give us more flexibility". This meant the staffing levels had been re-assessed and adjusted to provide people's care and support.

Staff support arrangements had improved. One member of staff told us, "Morale is picking up. We are having regular meetings and 'Shape your future' sessions to discuss our work. However, if I want to speak to the manager in private it's never a problem". This meant staff had opportunities to discuss their performance and development in private and together.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found that some people were being deprived of their liberty without the necessary authorisations in place. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection we looked at the care plans for seven people living in the home. We found that DoLS applications had been made on behalf of each person but mental capacity assessments had only been completed for four people. A deprivation of liberty can only occur where someone lacks capacity and therefore this needs to be assessed prior to any application and does not apply where people have capacity. The registered manager told us that they thought everyone living in the home would need a DoLS to maintain their safety. The registered manager said they recognised that a capacity assessment should have been completed prior to the DoLS application. However, they said as there was a waiting list for assessments they made the applications in advance and planned to complete capacity assessments with supporting best interest decisions for everyone's care and support. We saw that the progress of the assessments was logged on an action plan but there were no risk assessments in place to ensure people were lawfully protected whilst they were waiting for assessment.

Staff told us they had received training in understanding mental capacity. One member of staff said, "It was very interesting. It's all about looking for the least restriction. For example, [name] doesn't need to be restricted by bedrails but needs something to protect them from falling off the bed. We use foam wedges which are better and are less restrictive". This evidence demonstrates that improvements had been made in staff understanding but that further actions were required to fully comply with the Act.