Quality Care UK Limited

Lavender House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Lavender House is a residential care home providing personal care to up to 32 people. The service provides support to older people. At the time of our inspection there were ten people using the service. Lavender House accommodates people in one adapted building over two floors.

People's experience of using this service and what we found
The service was not well-led. The provider had failed to take action to improve or assess the safety of the service. Assurance systems to monitor risk and quality were not effective. Audits did not always identify issues and where issues had been identified these had not always been acted upon in a consistent and timely manner. Good practice guidance was not always considered and implemented.

The service was not safe. Routine servicing of equipment had not been completed. Staff did not always follow best practice to prevent and control the spread of infections. This put people at risk of harm. We could not be assured medicines were managed safely. Stock counts for people's medicines were incorrect and best practice guidance had not always been followed. People and their relatives felt the service was clean but not always well maintained.

There were enough staff to meet people's needs and staff had been recruited safely. Staff we spoke with were knowledgeable of people's needs, risks and safeguarding systems. Staff told us they liked working at Lavender House and the registered manager was approachable.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 3 April 2019) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider was still in breach of regulation.
This service has been rated requires improvement or inadequate for the last four consecutive inspections.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the

service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the management of risk, management of medicines and good governance at this inspection.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below

Lavender House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was carried out by three inspectors including one medicines inspector. An Expert by Experience supported the inspection by making phone calls to relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Lavender House is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. Lavender House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and

improvements they plan to make. We spoke with commissioners and the local safeguarding team for any recent feedback of the service.

We used information gathered as part of monitoring activity that took place on 02 February 2022 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spoke with 5 people and 6 staff members including carers and the registered manager. We reviewed documentation relating to health and safety, staff recruitment and the maintenance of the property. We reviewed 5 people's documents relating to their care. We reviewed documentation relating to the management of medicines, including the administration records for 10 people. We looked around the home to check whether the premises and equipment were suitably maintained and observed interactions between people who lived at the home and staff.

We spoke with the local fire service, local authority safeguarding team and the local infection control team during the inspection to ensure the registered manager had the correct support and advice.

After the inspection
We liaised with the local authority to share our inspection findings.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- The provider had failed to ensure environmental risk was consistently identified and managed. The premises and equipment were poorly maintained which exposed people to the risk of harm. Routine servicing of equipment had not taken place as required.
- People were exposed to risk of harm because fire safety was not robustly managed. The provider had failed to ensure a competent person had serviced the fire alarm and emergency lighting in a timely manner. We could not be assured all staff had received practical fire safety training.
- The risks of falls to people had not always been mitigated. The building's lift was not in working order at the time of inspection. There had been no consideration for how this could impact risk to people who now had to use the stairs and were at risk of falls.
- Staff did not always follow risk assessments as instructed. For example, we reviewed two risk assessments which instructed staff to complete checks on safety items such as sensor mats daily, these were only being carried out on a weekly basis.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People consistently told us they felt safe.
- We have informed the local fire service and the local authority of our findings. Following our inspection visit, we were provided with documentation to confirm the fire alarm system had been serviced by a competent person.

Using medicines safely

- We could not be assured people were receiving their medicines as prescribed. We checked the quantities and stocks for ten people and found balances to be incorrect for eight of them. There were no individual balance checks of quantities and stocks of medicine for each person.

● Detailed guidance specific to each person on how to administer medicines prescribed as and when people required them, known as "when required or PRN" was not available.
● Good practice guidance was not always followed. Handwritten MAR charts were not always signed by two members of staff to confirm dosage instructions had been accurately recorded. For example, the strength of the prescribed medicines had not been recorded for three people. One of these medicines being available in various strengths. Not administering medicines as directed by the prescriber increases the risk of people experiencing adverse effects from the medicines, or the medicine not working as intended.

Medicines were not managed safely. This placed people at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, we received assurances the provider had started to take action to improve the medicines systems at the home.

Preventing and controlling infection
● Although people and relatives told us the home was clean. We could not be assured that people were protected from the risk of spread of infection. Personal Protective Equipment (PPE) was not always used effectively. Staff were not always wearing PPE in line with government guidelines and PPE was not being disposed of correctly. We observed staff wearing their masks on their chin whilst supporting people.
● Areas of the home and equipment could not be cleaned properly and needed repair. For example, the bath hoist was rusted, various windowsills were chipped and there was limescale on taps.

People were at risk because there was poor prevention and control of infection. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Incidents and accidents were being recorded and monitored for themes and trends. This resulted in referrals being made in a timely manner when required.
● The registered manager held group supervisions following incidents to share learning.

Staffing and recruitment
● Only one person had been recruited since our last inspection. The correct checks had been completed and they had been safely recruited.
● There were enough staff to meet people's needs. People told us they were not waiting for their care and they had meaningful conversations with staff. One staff member said, "staffing levels are perfectly adequate, there is enough on the rota and we get quality time with people."

Systems and processes to safeguard people from the risk of abuse
● There had been no safeguarding concerns raised since our last inspection. However, the manager demonstrated their knowledge of safeguarding processes and systems.
● Staff had received training about safeguarding and demonstrated their understanding. One staff member told us, "Safeguarding is about people being at risk of harm, abuse or neglect. I would report to manager in the first instance. Or get in touch with CQC or safeguarding local authority if needs be."

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider failed to ensure a full range of effective systems were in place and fully embedded to demonstrate safety and quality were effectively managed. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider continued to fail to understand their roles and responsibilities and make the required improvements to ensure people received safe care. The provider has a history of failing to meet regulation requirements.
- There continued to be a lack of oversight of the service. Governance and quality assurance systems were not effective. Audits in place were of poor quality and had continued to fail to identify and act on the areas of concern we identified at the last inspection.
- There continued to be a failure to manage risk. This included the management of medicines, infection control, risk of falls, fire safety. Risks had not always been identified and recorded in people's care plans.
- The provider failed to take the necessary action recommended by external specialists to ensure people were receiving safe care. For example, the provider failed to implement recommendations and actions set by the local fire service in a timely manner.
- The provider was not following their own policies in relation to infection control or medicines. For example, in relation to mask wearing and PPE disposal.
- The provider did not have a service improvement plan in place and had made little improvements to the premise since the last inspection and had not acted upon issues raised in 2019. For example, the bath hoist was identified as requiring attention in 2019 and this had not been serviced or replaced at this inspection.

Failure to have effective systems in place to manage quality and safety put people at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● There had been no instances whereby the provider had to exercise their duty of candour. However, the registered manager demonstrated knowledge of this process and when it would be applicable.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The registered manager told us they did not always get the required support from the provider to make vital changes to the service. Staff we spoke with said they observed the registered manager not receiving the support required.

● Staff told us they liked working at the service and could approach the manager. One staff member we spoke with said, "[the manager] says if you need anything just give me a ring anytime and they really mean it. They are so easy to work with and cares so much about everyone."

● People and relatives commented on the consistent staff team. One staff member said, "We work together, and people are not waiting. Residents are the most important thing; we know their needs well. We always assist them and are guided by them."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Information and recommendations made by partnership organisations such as the fire service or the local authority contracting team were not always acted upon.

● Feedback was not actively sought from people regularly visiting the service such as health or adult social care professionals.

● Resident meetings were carried out by the registered manager. People we spoke with knew who the registered manager was and said they would feel comfortable approaching them on a one to one basis.

● Relatives told us they had been asked for their feedback. Relatives told us they felt able to raise any concerns with the registered manager and praised the communication of the service. One relative we spoke with said, "The manager is approachable, chatty and always happy to help."

● Staff we spoke with felt the manager valued their opinion.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12(1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines were not managed safely. This placed people at risk of harm. This was a continued breach of regulation 12(1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk because there was poor prevention and control of infection. This was a continued breach of regulation 12(1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have served a warning notice to the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to have effective systems in place to manage quality and safety put people at risk of harm. This was a continued breach of regulation 17(1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We have served the a warning notice to the provider.