Slough Borough Council

Lavender Court

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**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Lavender Court is one of two care home services the provider is currently registered for.

The service provides accommodation and residential care for up to eight adults with moderate to severe learning disabilities. Lavender Court is situated in residential area of Slough, Berkshire. The building is a large, detached bungalow on one level. There are eight single bedrooms with a lounge area, a separate dining room, kitchen, office and communal bathrooms. There a large patio and garden at the rear of the premises. Although not registered with us, there is also a separate day services building adjacent to the service, which provides a base for activities such as IT, music, exercise, cooking or arts and crafts. People who lived at Lavender Court attended the day centre at various times from Monday to Friday.

At the time of the inspection, there was no registered manager. 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. Leading up to the inspection, we were required to complete an administrative cancellation of the former registered manager, as they have failed to cancel their own registration. The home manager at the time of our inspection had not applied to add Lavender Court to their existing registration.

Since registration under the Health and Social Care Act 2008 on 20 January 2011, Lavender Court was inspected four times. The most recent inspection was a routine planned visit on 19 December 2013. We inspected five outcomes which were compliant. This inspection is the first visit under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the first rating under the Care Act 2014.

People who used the service were protected from abuse and neglect. Appropriate systems were in place to ensure that any allegations would be reported for assessment and investigation. The service was unable to tell us if any allegations were ever referred to the local authority. There were no records which showed allegations of abuse or neglect.

Some risks for people and the service were assessed, mitigated, documented and reviewed. Risk assessments related to people's care required better oversight. We found that some risk assessments were missing. For example, one person who had routine falls and others who had epilepsy did not have specific risk assessments to prevent harm. Risks from the building were considered and managed, although records were not kept in an organised format.

We looked at two staff personnel files. The location's home manager was responsible for ensuring fit and proper person checks were completed and recorded for new staff. We found the service had strong recruitment and selection procedures that ensured suitable, experienced applicants were offered and accepted employment. Personnel files contained all of the necessary information required by the regulations and no documents or checks were missing.

Medicines were safely managed. We examined the handling of people's medicines during our inspection and found that people were safe from harm. The home manager explained there were no medicines incidents. However, even potential failures in practice that did not result in harm to people required reporting. We advised the provider to seek guidance and support to ensure any medicines incidents were always recorded and reviewed.

The deployment of staff was unsafe and inappropriate. Although organisational restructuring was evident, the safety of people was placed at risk due to inappropriate changes in the staffing levels and roles. People's dependency levels and satisfactory risk assessment of staff numbers on day shifts were not considered. We observed numerous instances during the inspection where people were at risk because the available staff were busy. The staffing deployment also impacted on people being able to leave the building when they wanted or indicated to.

Staff training, supervision and performance development were lacking. At the inspection we were told that satisfactory records for staff training and supervision were not able to demonstrate appropriate levels of staff support. We wrote to the home manager after the inspection to provide the opportunity for further evidence to be collated.

The service was compliant with the requirements of the Mental Capacity Act 2005 (MCA). The recording of consent and best interest decision making ensured the service complied with the MCA Codes of Practice. People were deprived of their liberty in line with the MCA and associated procedures.

People received nutritious food which they enjoyed. Hydration was offered to people to ensure they did not become dehydrated. Snacks and treats were available if people wanted or chose to have them.

People who used the service were unable to communicate their feelings to us about the care. We found care workers had put in extra effort to ensure that the service was caring. We observed staff were warm and friendly. As staff had worked with most people over an extended period of time, they had come to know each person well. Relatives and advocates we spoke with described Lavender Court as caring.

Personalisation of people's bedrooms was evident. Communal spaces were not personalised or provide a homely feel. The garden and other outdoor spaces were unkempt. People had access to the nearby day centre, but there were limited other opportunities for social stimulation. We saw people's privacy and dignity was respected at all times.

Responsive care was provided to people. Their wishes, preferences, likes and dislikes were considered and accommodated as far as possible. Staff knew about the complaints procedure. There were no complaints since our last inspection, however there was also no information available to people and others on how to make complaints.

The workplace culture at Lavender Court required improvement. Despite changes in management of the service, there was a low staff turnover. The service failed to notify us of significant events in line with the regulations. This meant we could not effectively monitor the compliance of the service. A series of audits and checks were not routinely conducted to ensure good governance and quality of care.

We found eight breaches of regulations as a result of this inspection. 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 were protected from abuse or neglect.

People's risks were not always adequately assessed and mitigated.

Risks from the building and equipment were not adequately assessed, mitigated or reviewed.

Staff deployment was not safe.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Appropriate levels of staff training, supervisions and performance appraisals had not occurred.

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

People were supported to maintain a healthy, balanced diet.

People were supported to have access to healthcare services and receive ongoing support from community professionals.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion.

As best as possible, care plans and decisions were made with the person's assumed preferences.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

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

Staff had excellent knowledge of the people they cared for.

People's social lives and community participation were limited by factors beyond their control.

Information about the complaints process was not satisfactorily displayed or communicated.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a workplace culture not conducive to a care home.

Meetings and feedback were not used to monitor the quality of the service.

Audits were not in place to determine the quality of people's care.

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 was undertaken by two adult social care inspectors. One inspector visited the location on 11 November 2016 and one inspector conducted telephone interviews with people's relatives and advocates in the week commencing 14 November 2016. This inspection was unannounced.

For this inspection we asked the provider to complete a Provider Information Return (PIR). 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 did not receive the information before our inspection. We reviewed information we already held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. We asked the local fire authority for information to aid our inspection.

During the inspection we spoke with the home manager and seven care workers. We also spoke with two of the provider's human resources staff. We were unable to verbally communicate with people who used the service at the time of the inspection. Instead we observed their day-to-day living practices and non-verbal behaviours displayed to care workers and us. No visitors or relatives were present at the service on the day of the inspection. The home manager provided us with a contact list so we could conduct telephone interviews with relevant parties. We telephoned relatives and advocates after the inspection to gather further feedback about the service. We received feedback from three of them.

We looked at three sets of records related to people's individual care needs. These included care plans, risk assessments and daily monitoring records. This included both paper-based and computer-based records of people's care. We also looked at two staff personnel files and records associated with the management of the service, including quality audits.

There were a number of documents and some evidence not available at the service during the inspection.

We asked the provider to send further documents after the inspection. The provider sent documents to us after the inspection. We have considered the documents as part of our inspection process.

We looked throughout the premises and observed the external environment of the building. We also observed routine care practices and people's interactions with staff during the inspection.

Requires Improvement

Is the service safe?

Our findings

We were unable to tell whether people who used the service felt safe. However, we observed they were comfortable with staff on the morning and afternoon shifts. We found people were protected from abuse or neglect. Staff we spoke with told us they had previously received training in safeguarding people at risk, although they were unsure of the training dates. When we asked staff, they clearly explained what they would do if they felt a person was at risk of harm, abuse or neglect. The care workers knew allegations of these types of events required immediate action and reporting to management. Safeguarding posters, resources or useful telephone numbers for reporting abuse or allegations were not displayed in areas frequented by staff, like the office. One care worker we asked showed us how to access the provider's safeguarding and whistleblowing policies on a computer. The home manager was unable to tell us of any safeguarding referrals to the local authority. We contacted the local authority's adult safeguarding team to check whether any abuse or neglect referrals were made. They responded that two historical medicines errors were reported, but no other information of concern was received about people who used Lavender Court.

We looked at how Lavender Court protected people from risks related to their care. There was evidence of satisfactory types of risk assessments, including those related to the accommodation, moving and handling and behaviour management. The risk assessments we viewed were not regularly reviewed and updated. We saw that risk assessments were last printed in 2014. For 2015 and 2016, the previous manager had signed and dated the bottom all of the pages and written 'no changes'. The service used a key worker system, which meant each person had a named care worker who oversaw their entire care package. There was no evidence that the key worker or even other care workers had reviewed the risk assessments since they were first printed in 2014. We could not find evidence that over time, people's risks were satisfactorily reviewed in order to ensure new risks had not developed or existing risks increased.

People's individual risks were not always appropriately assessed, documented or mitigated. We found one person had started to experience regular falls. However, there was no specific risk assessment for the person to show how falls could be prevented by staff. Other people were diagnosed with epilepsy, where any seizures could place people at risk of harm and injury. The people did not have specific risk assessments related to their epilepsy. Another example was that a person's weight was considered to be unsafe. They were seen by a dietician and appropriate interventions were taken in an attempt to maintain a safe body mass index. However, the person's weight was not routinely recorded on a recurring basis. We observed an eight month and a five month gap in the recording of the person's weight. This placed the person at risk because the dietician would need the information about the person's weight at the next scheduled review. The person's risk assessments did not include one for malnutrition.

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

We examined the risks from the premises and grounds, and looked at safety records related to these. We saw that a contractor was used for routine maintenance tasks and they responded quickly when issues were reported by staff. Staff found it difficult to provide some evidence about the premises and grounds safety

checks performed. We found some checks were recorded on paper-based forms and were told some reports were stored on a computer. We looked at safety of water temperatures and found these were checked weekly by staff and routinely recorded. This was good practice.

We also looked at the prevention and control of Legionella. We were presented with two different folders which contained similar information, but neither was comprehensive or showed how a system was in place to ensure Legionella did not develop in the water. We asked the home manager to send us the Legionella risk assessment after the inspection as it could not be located at the time. The Legionella risk assessment was received and showed 'moderate' overall risk. There was also evidence received from the service that prevention and control of Legionella was conducted by a contractor. We saw the risk assessment dated 13 April 2015 required 14 remedial actions to ensure people's safety from Legionella. The service did not show that since the risk assessment was completed, the remedial actions were completed to mitigate the risks identified. The risk assessment was also not reviewed to determine if the 'moderate' overall risk was reduced by any actions that were taken. Water sample results were not provided to us to show that Legionella did not exist in the water at Lavender Court.

People were at risk from the service's failure to ensure safety from electricity. We requested information about the electrical safety to be submitted after the inspection. We received portable appliance testing (PAT) results, but these were from October 2013. The service did not show adequate evidence that portable electrical appliances were tested more regularly. We also received the building's fixed electrical wiring report dated 3 April 2014. This showed the electrical system in the building was 'unsatisfactory' and required some repairs. The service also sent evidence of a quote for repairs from May 2014. We were told the remedial repairs were completed, but received no evidence to show this.

The service had its own fire risk assessment dated 26 June 2015 which showed the risk as low. We spoke with the local fire authority and found the building was last inspected on 31 May 2015 and found 'broadly compliant'. There was a recommendation from the fire authority that internal emergency escape routes required better signage. This was not completed by the service and we made the home manager aware of this. When we viewed the grounds outside the building, there were risks to people who used the service. A large amount of broken equipment and items for discarding were stored outside. There were obvious risks to people of falling over the items or unsafe access to them.

We found chemicals were safely stored away, except for one bottle. This was a cleaning product stored underneath the unlocked kitchen sink. People could have accessed this and ingested it if they were unsupervised. Safety data sheets about the chemicals were not present at the service and when we asked, staff were unaware of what they were. Safety data sheets are provided by manufacturers where there is a risk from a chemical or product, and explains what to do if there is a spillage or ingestion of the substance.

We recommend that the service promptly implements a robust system for the management and storage of all documents related to the safety of the building and grounds.

Our inspection took place from 8.20am to 6pm. During this period, we observed two care workers completed a morning shift and two care workers were deployed during the afternoon shift. Another care worker attended the service on her day off to help us with the inspection. A small number of care workers from a nearby respite care home and day centre visited during short periods of the day, but did not provide care to people at the service. The home manager was available only during the afternoon part of the inspection, due to an existing commitment elsewhere. Three people who used the service left the building and participated in activities for a few hours in the nearby day centre. We considered this when we examined whether there was a safe staffing deployment at the service.

We found the service did not always have safe staffing deployment. We closely observed what people did and what tasks care workers performed during the inspection. The number of people who used the service was mainly constant and most had lived at the service for lengthy periods of time. We reviewed the deployment of all staff within the service. We were advised of the daily staff shift patterns and deployment. At the time of the inspection, six people lived at Lavender Court. Earlier in 2016, three care workers were always deployed during the morning and afternoon shift. Since one person who used the service had left Lavender Court, a managerial decision was made to change the day staffing to two care workers instead. As the provider also operated the respite care home across the road, it was determined that staff could work across both services to meet people's needs. The home manager explained that there should always be two staff in the building on a morning and afternoon shift. We observed some periods during the inspection where one of the two staff had to leave the building, for various reasons. This meant sometimes only one care worker remained in the building with people who used the service.

All six people who used the service were able to mobilise independently. This meant they could stay in their bedroom, go to communal spaces or walk around inside the building. We observed multiple occasions when people were left to their devices. During the morning shift, two care workers had to complete the medicines round. This meant they were required to focus on the safe administration of medicines, and not be interrupted by people's other needs at the time. After this, people needed their breakfast prepared and personal hygiene assistance. We observed one care worker go into a bedroom with one person and another care worker prepare the meal. We witnessed people wander about without any form of supervision from staff, as they were already otherwise engaged. This continued when one care worker had to focus on helping people eat their breakfast. The other care worker was still busy with another person's personal needs. Two people had to wait a lengthy period of time for their breakfast or drinks. One person poured hot tea down the front of themselves as they were consuming it. However the care worker helping people with eating and drinking had a delayed response because they were helping another person.

During the inspection, one person stood by the front door with their coat on for long periods, and then repeatedly approached staff pointing to his coat. When we asked what this meant, care workers told us the person liked to go outside. However, they explained that as there was only two staff at any one time, they could not safely take the person anywhere outside the building. Although the care workers acted kindly to the person, they were required to make continual explanations to him about why he could not go outside. People were also unable to go out in the yard of the premises. This was again because if they went outside, they would be at risk of harm from a lack of staff supervision.

We spoke with seven care workers about the staffing deployment. All of them described the situation as unacceptable and unsafe. One care worker told us it was 'dangerous'. They told us they felt under pressure, feared that people would experience harm and were annoyed that people were not able to have the care they needed at the right time. Our observations at the inspection supported the staff's feelings. Despite this, we saw that staff did the best they could under the circumstances. We examined a typical monthly rota. We saw there was a reliance on agency staffing, and that some had to be contracted in an ongoing basis. There were vacant posts but it was not clear how or whether these were being recruited to. When we spoke with the home manager regarding how staffing was calculated and staff were deployed, it was clear this was linked to the number of people who lived at the service, not their dependency level or individual needs. There was no use of satisfactory tools or appropriate calculations to determine what a safe staffing deployment would be. Staff also described limited occasions when just one care worker was left inside the building with people who used the service.

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

In conjunction with the provider's human resources (HR) team, the home manager was responsible for ensuring fit and proper person checks were completed and recorded for new staff. We found the service had strong recruitment and selection procedures that ensured suitable, experienced applicants were offered and accepted employment. We looked at two personnel files for staff. We found personnel files contained all of the necessary information required by the regulations and no documents or checks were missing. We saw this included criminal history checks via the Disclosure and Barring Service (DBS), checks of previous conduct in other roles, and proof of identification. The service correctly checked and recorded staff's right to work in the UK. The service ensured that satisfactory checks of applicants' prior work conduct (references) were in place. Where necessary, the service obtained additional references to ensure that applicants were suitable for carrying out personal care. People were protected because the service had strong recruitment and selection procedures.

Peoples' medicines were managed and administered safely. We checked the room where medicines were stored and controlled for the entire care home. We saw that medicines were correctly locked away. The medicines room temperature was monitored and a process was in place to ensure that the room did not exceed the recommended storage conditions. We examined three medicines administration records (MAR) and found that these were fully completed and in line with administration requirements. We did not find missed signatures on the MARs. A care worker explained a robust checking mechanism was in place to ensure that medicines errors did not occur. This involved one care worker administering the medicines, one care worker checking this and a third care worker later on counting stock and checking the MARs.

Staff were required to undertake specific training in medicines safety and administration. Staff were also subject to competency checks to ensure they followed safe processes. The competency process and tool was robust and had a good underlying rationale. We saw one staff member's competency record showed that they had completed an extended, repeated competency-checking process. This was completely unnecessary. The care worker was experienced in medicines administration and should have been checked to be safe at the service-level in a reasonable fashion. We questioned the care worker why this was and were told it was a managerial decision and they did not realise the repetition of the checks. We then asked the home manager why this had occurred and pointed out the record to them. They agreed this was not the intention of the competency checks, and they would take immediate action to ensure that the care worker was considered safe at medicines administration.

We also observed medication being given to people throughout the inspection, and found that care workers followed the correct procedure. The home manager told us there were no recorded medicines incidents.

Requires Improvement

Is the service effective?

Our findings

Nearly all of the staff who worked at Lavender Court were experienced care workers and were employed by the provider for a number of years. During the course of the inspection, we spoke with care workers about what training and supervision they were offered or received. Four care workers we spoke with were able to tell us basic information about the training and supervisions they had participated in. However, the care workers were uncertain of dates they attended, did not know the frequency they should repeat training and were unsure when the next training sessions were. All of the staff we spoke with confirmed that they received training at times in various relevant subjects specific to their role. Staff expressed they had received less frequent supervision sessions with their managers over time. They felt that with the organisational restructure taking place, they had less time with managers to discuss their own performance or plan personal objectives for the future. When we asked staff, there were no visible areas in offices that upcoming training or leaning and development sessions were displayed.

People who used the service were unable to tell us whether they felt staff were knowledgeable and skilled in their roles as care workers. We telephoned relatives and people's advocates to seek their feedback. At the time of the inspection, the service was unable to show records of the frequency and dates of staff training, supervisions or performance appraisals. We were shown a folder with staff certificates of attendance at training. However, this was not comprehensive evidence for us to make a proportionate and reasonable decision regarding staff knowledge and skills.

We wrote to the home manager after the inspection to request the information be sent to use for consideration. The home manager provided a response which included examples of some staff training certificates and the information they could locate about dates and subjects for staff training. Evidence of staff supervision sessions was limited to historical information about two staff members and no evidence of performance appraisals was provided. The service experienced a change in managers in 2016. This meant electronic records about staff training, supervision and appraisal were unobtainable. We considered this as part of our inspection process as well as the evidence the home manager was able to send. The service was unable to demonstrate that staff received appropriate training, supervision, support or performance reviews.

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

We observed staff in their roles during our time at the care home. We saw they were skilled in the type of tasks they completed. This included mainly personal care, such as feeding people or helping them with personal care. It also included medicines administration and documentation of care they had provided. Other tasks were completed by care workers which included cleaning and cooking. We found that staff were skilled which enabled effective personal care for people.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found people who used the service did have mental capacity assessments in their files. These were not completed by the care workers or management, but by other healthcare professionals who visited the service as part of their role in the care of people. The risk assessments and personalised care plans contained basic information about people's mental capacity. This was so that care workers were aware of whether the person could make any decisions for themselves. Care workers we spoke with were very clear about people's mental capacity and their ability to make any decisions or consent to anything. We saw some people who used the service could make no decisions for themselves based on their complex learning disabilities. Where complex decisions were required regarding people, best interest decision making was utilised, and the least restrictive decision was implemented. This was in line with the MCA Codes of Practice. Information about people's mental capacity assessments, their ability to consent and best interest decisions was not clearly filed or sorted, and this made it difficult to determine whether the service had complied with the consent regulation.

We spoke with a care worker and the home manager regarding standard DoLS authorisations for people who used the service. The care worker was unable to give us information about people's DoLS applications or authorisations. This was because they were not responsible for this, and the former registered manager was the only staff member who completed this process for people who used the service. We looked at six people's care documentation. We saw that there was evidence of previous DoLS applications and authorisations in the files we viewed. There was also evidence that the former registered manager of the service had e-mailed the provider's DoLS team to seek information about DoLS assessments and when visits to the person would be conducted.

The home manager at the time of our inspection did not have the necessary information about people's DoLS statuses. We contacted the local authority DoLS team in an attempt to gather information about people's deprivation of liberty. We could not be assured, based on the available evidence provided to us at the service, that people were lawfully deprived of their liberty in line with the MCA and DoLS requirements. The DoLS team confirmed that all people's standard DoLS authorisations had lapsed in June 2016 and no further applications were made by the service. Standard DoLS authorisations can only be issued for people in hospitals or care homes.

Changes to the service were planned and a lengthy consultation and development process were underway and ongoing. We were told by the home manager that the care home would be changed to supported living. This meant people would not be able to have DoLS authorisations in the same way as the ones which expired. Due to the intended changes to the type of service people used, the provider had instead applied to the Court of Protection (CoP) to deprive people of their liberty in a community setting. This was in line with the required process. At the time of the inspection, no decisions had been made by the CoP and so the outcomes were pending.

People had access to adequate food and drinks. We checked the cupboards, refrigerator and freezer and

saw that a selection of appropriate groceries was present. On the day of the inspection, an online grocery delivery occurred and was packed away by the care workers, which replenished the supplies. We did note that the freezer was frosted over, and that some products, like meat, would be considered inedible because of their condition. We made the home manager aware of this in our feedback at the end of the inspection. People's preferences regarding food and drink were sometimes considered by staff. For example, care workers knew what people liked or disliked and this matched the information in their care documentation. However, people were often treated as if they were required to have the same thing as everyone at the time. For example, breakfast consisted of a large pot of porridge and served to all of the people who would eat it. Although people received satisfactory meals, there were no alternatives. Pictorial use of food symbols and the display of menus for the week were not evident. This could have assisted people to understand food that was served or available. The menu plan was however rotated and seasonal, so that repetition of the same meals was lessened.

People at Lavender Court were supported to maintain good health. As far as possible, people were supported by the service to attend all necessary medical and healthcare appointments away from the care home. Examples of good support to people related to healthcare included assistance with GP visits. Care workers we spoke with described some instances where the person themselves would not wait at a healthcare establishment, and other suitable alternatives were used. We found evidence that other appropriate healthcare professionals attended Lavender Court on occasions. Where additional support was required to help with health appointments, the service provided escorts for people, if required. Staff we spoke with were knowledgeable about people's ongoing health matters, especially their learning disability diagnoses and individual personalities. The service had a strong relationship with the local authority team for people with learning disabilities. We found that the filing of people's medical information in their care folder needed review to ensure a better ability for the staff to find the relevant information.

Good

Is the service caring?

Our findings

People were unable to tell us themselves whether the service was caring. We used observation and other evidence to determine whether the service was caring. We found the service was caring. One person's advocate we spoke with gave positive feedback about the care. They had not visited for over 12 months, but felt there was good non-verbal communication between staff and people who used the service. They explained that there was positive interaction with staff, and that the staff could understand the person's 'individual indicators'. The advocate confirmed that care workers accessed external professionals for people's care in a reasonable way. In addition, the advocate told us that care workers helped people to successfully maintain family connections.

A family member we spoke with also gave positive feedback about the care. They said, "If we weren't happy, [the person] wouldn't be there." The family member said there was, "Excellent communication" and that the person's key worker kept them informed of any issues or concerns. They said they were told about the person's "Good or bad." The family member added the person had, "A very good social life" and that "[The person] looks clean and tidy." Another relative we spoke with considered the service was caring. They said, "[I have] never had any concerns about the service." The relative told us they were aware of a lot of changes, they didn't visit very often, but felt informed of anything important. When we asked the relative whether the service was caring, they replied the person was, "Very well cared for." The relative went on to say the person, "Has a social life", and confirmed they were involved in care reviews and received relevant reports.

We saw there was a board on the wall at the entrance, with the names and pictures of which staff would be on duty for each shift. This showed that the service had given consideration to the importance of showing this information with the people who lived there. Staff did not wear uniforms or badges and dressed in an appropriate manner which helped them to work closely with people in a friendly way. We saw there was limited decoration throughout the home, excluding people's bedrooms. The garden and outdoor spaces were in a poor condition. Staff told us this disappointed them. They felt that people would have benefitted more from being able to access the outside area. They explained that doors to the area remained locked almost all of the time. The care workers showed us a nice picture of the garden from the prior year, when it was awarded first place in a local competition.

None of the people who lived at Lavender Court could communicate verbally with staff. We saw good use of staff observing people's non-verbal behaviours to understand the person. For example, we saw staff watched people's facial expressions and listened to sounds they made. In addition, we found staff watched people's movements and other physical behaviours to understand what they wanted to do. This did rely on staff's knowledge of the person, their likes and dislikes and interpretation of what various things meant. Alternative methods of communication with people were not used. The care workers told us that one person could use Makaton in a limited capacity. Makaton is a form of basic sign language that people with a learning disability can learn and use to communicate with others. We saw the person and a care worker use Makaton to understand a particular subject they communicated about. There was a lack of adaptation at the service to ensure people were able to express their views. A very limited amount of information, processes or choice was displayed via symbols, pictures or photos. When we asked about the menu, the

folder with pictures in it was on a shelf in the staff office.

People were not able to contribute to their own care planning. This made the care planning process difficult for the staff responsible. Key workers were used, to ensure that each person had a dedicated member of staff who knew them best. The best available information about each person was used by the key workers to help formulate their care plans. This was collected by care workers and management from a variety of sources. There was a reliance on information about people from other agencies and healthcare professionals to generate accurate care plans. There was evidence that independent mental capacity advocates (IMCAs) were routinely involved in people's best interest decisions. IMCAs are professionals that should be involved in people's care planning or decision-making where the person lacks the ability to do so for themselves. IMCAs are often used in these processes when there are no suitable alternatives, like relatives or attorneys. When we looked at the care documentation, we found little evidence that people or relatives were involved in the planning process. In addition, no use of alternative communication methods, like easy-read versions of documents, was produced. Staff were required to make less important decisions about some aspects of people's care, which was acceptable.

We saw staff treated people with dignity and respect at all times. People who lived at Lavender Court did not know how to protect their own dignity or ensure personal privacy. Therefore, they relied on care workers to ensure this. We found that staff were mindful of this when they provided care with people. People's support with staff was always completed with their implied agreement. We did not witness any instances where staff forced people to receive care or participate in a task. We observed staff speak with people who used the service in a conversational style and, most of the time, encouraged them to undertake aspects of their usual routines. This had a positive effect, as some people did not understand what tasks were routine in their life. We observed staff knock on people's bedroom doors when they were closed. We saw staff announced their presence and to people when they were in their rooms. People's rooms were decorated by themselves and in the style of a bedroom in a private house. There were things in the bedrooms important to the person and items that they liked to have.

We did not see any relatives, friends or visitors during the inspection. However, we did find that the care information contained the necessary information about family members and important others for the people. Care workers were also knowledgeable about people's relevant friends, family and advocates.

Confidentiality in all formats was maintained, especially in electronic records. We noted computers required a user password to access, and again when they were not used for a period of time. We did not observe any instances of people's personal information being located at an inappropriate place within the building. Confidential personal information was stored only within locked offices. The service did however need to improve the archiving of paper documents not being used on a regular basis. This was to ensure for the purpose of their care and accommodation, only the most relevant information about people was being used at any time.

Requires Improvement

Is the service responsive?

Our findings

People were unable to tell us whether the care was personalised or responsive to their needs. We reviewed records and observed care practices to determine whether the service was responsive. We looked at three people's care documentation. We found people who used the service had their personal needs and preferences taken into account before care commenced and throughout the continuation of their accommodation. In each of the care records there was good evidence of pre-admission planning which in itself gave a picture of people's needs and also whether the service could meet those needs.

Care workers we observed had a good knowledge of the people who lived at Lavender Court. We witnessed one incident where a person became very agitated for no apparent reason, and laid down on the floor. The care worker who noticed this knew exactly what the person intended. We asked the care worker to explain this to us. The care worker gently and calmly guided the person to the area in the service where they wanted to be. The staff member explained that the person had a favourite chair, and when they were not actively participating in something, liked to be in the chair. We later observed that the person, once seated in their chair, was completely comfortable and relaxed. This was a positive example of the staff member's response to the person's behaviour.

There was evidence of comprehensive, individualised care planning within the care files we reviewed. We found the care plans were well-written and incorporated personal details specific and relevant to the needs of the person. Care plans were typed on computer then printed, and easily updated if details about the person changed or required review. The care plans we viewed were current and accurate. We compared the care plans we viewed to two of the people who used the service and found they were consistent with the person's needs. People's preferences, likes and dislikes were thoroughly documented and gave a clear picture of how the care should be provided.

People were encouraged by care workers, as far as possible, to maintain an active lifestyle. The layout of the building meant that easy access inside and outside was provided. People did not go out to the garden on the day of our visit, although we could see they were interested in what was outside. There was a nearby day centre for people with learning disabilities, and it offered a wide range of stimulating and positive experiences. We visited the day centre to see what three people from Lavender Court participated in during the morning part of our inspection. People were able to access the day centre to join in programmes, but on a rota-based system only. They were not able to go to sessions if it was not their allowed day or time. One person who was due to go to an activity at the day centre in the afternoon session did not attend. When we observed this, we asked staff why the person did not go. They told us changes in the person's medicines had caused drowsiness. The staff said if the person went they would simply fall asleep with no benefit of attending. This was not communicated to the GP or mental health nurses to ensure that this was reviewed for the person.

A contact we spoke with confirmed that people's social lives were sometimes restricted. They told us that one person was, "Drugged up to the eye balls when you visit" and that, "Very little goes on, compared to when they used to go out." The contact said they were told by the service that people received more 'one to

one' care, but did not believe this as they felt there were not enough staff to achieve that regularly. The contact further commented that, "They have upped [the person's] medication because [the person] is bored and becomes unsettled." The contact we spoke with felt this had caused negative consequences for the person's social life.

We found there was no ready supply of equipment and materials to support activities within the service itself. The interior of the building was bland and needed redecoration appropriate for the people who lived there. We were repeatedly told that changes to the service were planned, but these were protracted and a clear timeline for any refurbishment could not be confirmed. We found the television was on a radio station with pop music for the majority of the time of our inspection. Care workers tried to involve people in singing popular songs during the course of the day, and it was obvious that one person liked the music being played. Other than this, staff did not plan or carry out any form of other satisfactory entertainment or stimulating experiences. Despite having available transport for people, there were not enough staff on any shift to allow people to go out to the community other than to the day centre across from the service. Amendments were needed to ensure people who had difficulties could still participate in social interaction. Care workers told us they were frustrated with the situation, and felt people's lives were impacted unfairly.

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

The provider had a complaints policy and procedure. We observed a copy was easily available for staff to access. However no mechanism was in place to ensure that people who used the service, relatives, visitors or advocates were aware of the process for raising a complaint. We observed there was no signage in the communal areas of the service to explain how a complaint could be lodged. There were no easy-read versions of how people who used the service could make a complaint. Signs or posters with pictorial expressions on them, which people could point to, were also not used at the service. When we asked the home manager about complaints signage, they were sure a sign was present in the communal areas for people. However, when we checked with them, the sign was not in the entrance or hallway, but pinned up in the staff office. This was in an area where people would not necessarily normally access. There were no complaints forms or 'log sheets' and no process of how anyone could make suggestions. No compliments were displayed in communal areas.

Staff we spoke with knew about the complaints policy and the steps they would take if a person or relative wanted to make a complaint. Most of the care workers told us they would refer a complaint to the home manager. The service's policy and procedure contained the information for management regarding their role in listening to and managing complaints. We saw there was the ability to escalate complaints through the provider if people felt their complaint was not handled well. We were told there were no complaints since our last inspection. We could not be assured this was accurate. Due to a change in the service's management in 2016, it was not known where complaints were previously stored or filed. As a regulator we had not received any complaints from members of the public and no whistleblowers had contacted us.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

People were unable to tell us themselves whether the service was well-led.

The conditions of the provider's registration require a registered manager to be in post at the service. In the planning of our inspection, we found the former manager failed to cancel their registration with us when they left their employment at the service. We cancelled the former manager's registration prior to the service visit, when the current home manager and nominated individual confirmed the former manager was not in post. This was on the grounds that another person, the current home manager, would need to apply to be the registered manager. The home manager and nominated individual stated that they had contacted us to ask how they should proceed with the registration of a new manager for the service. We provided necessary guidance and support to enable them to undertake this. Leading up to our inspection, and knowing that the former manager had left their position on 16 September 2016, no one had applied to be the registered manager for Lavender Court. We have again informed the home manager and nominated individual of the need to comply with the conditions of their registration. We will continue to monitor this to ensure that the provider takes the necessary action of submitting the appropriate registration application.

We found the service failed to notify us of necessary changes or events at Lavender Court, in line with the required regulations. When the registered manager left their position and a different home manager commenced oversight of the regulated activity, the provider was required to notify us using a statutory notification. A notification is information about important events which the service is required to send us by law. Our records show the service did not formally submit this notification to us, although they did communicate this to our responsible inspector. Without the submission of such forms to us, we are unable to satisfactorily monitor services to ensure people receive safe, compassionate and high quality care.

This was a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009.

All services registered with us are required to have a statement of purpose (SoP). An SoP is a legally-required document that includes a standard set of information about a provider's service. The information in an SoP must always be accurate and up to date. The law says that services must notify us whenever changes are made to the SoP, and must tell us about the detail of the changes made. The service has to do this within 28 days of making any changes. Prior to the inspection, our records showed no notifications were sent to us about changes in the service's SoP. At the inspection, the service's SoP could not be located. In addition, we found a revised version was not submitted when there was a change in the home manager months before the inspection.

This was a breach of Regulation 12 of the Care Quality Commission (Registration) Regulations 2009.

Our previous inspection of Lavender Court was in December 2013. We found evidence that since then, people who used the service had standard Deprivation of Liberty Safeguards (DoLS) authorisations granted by the relevant local authority supervisory team. We saw the authorisations in people's care documentation when we checked the service's compliance with the Mental Capacity Act 2005 (MCA) at the inspection. In line

with the relevant regulations, the provider was required to formally tell us each time a person was granted (or denied) a standard DoLS authorisation. Our records indicate we received no notifications from the provider since their registration in 2010 under the Health and Social Care Act 2008.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We were aware that the service was in the process of significant organisational change, which included restructure and planned building refurbishments. This was explained to us by the home manager and nominated individual. The organisational change was still majority in the planning phase, although some staffing arrangements were changed in 2016. This included the implementation of a shared manager across the provider's services, an administrator leaving their post and the introduction of increased senior care worker positions. The home manager explained the provider's consultation with relevant parties was underway and they were kept informed throughout the process.

Some contacts we spoke with were not satisfied by the provider's plans. They felt changes to people's routines during the redevelopment would have an unpleasant toll for them. One relative told us, "Like a building site; there will be chaos and it will affect the residents…They [staff] have been to meetings but to be told, rather than consulted." Another relative stated, "So-called consultation. They already knew what they were going to do." The relative described their feeling of a 'hidden agenda'. The relative went on further to say, "They need to cut the budget and have been quite open about that." Another relative we spoke with was also dissatisfied with the organisational change. They said they were anxious about changes, especially as the last manager was 'so good'. The relative stated the prior manager, "Gave wonderful service" and, "All has changed recently and it is still good, but too soon to make a judgement. New manager seems to be capable and is very nice."

One letter was provided to us which showed a compliment from September 2016 about the former home manager. The letter stated, "...I have appreciated your care of [the person] over all these years. Your leadership of Lavender Court was always there and I'm sure showed the way for many care staff." This was good feedback about the management of the care home. We found there were no routine surveys over time of how people, relatives or staff felt. This meant the service and management did not measure the satisfaction of relevant people over time, ask for suggestions or have clear communication on an everyday basis. We found no signage within the service, no posters or fact sheets so that staff and visitors could read about the changes and their progress. The lack of this information being readily available resulted in uncertainty and speculation.

Staff explained a negative workplace culture at the service. When asked why, they related their experience of working at the service to the changes in the operation of Lavender Court. Although they appreciated the former home manager, their feeling was they had not yet established an effective rapport with the current home manager. The staff explained changes in their deployment meant that they now worked across two of the provider's locations, instead of just Lavender Court. Some care workers told us they considered leaving their roles, but valued their length of service. They had decided to accept the change, although not all of the staff were satisfied by the method in which the altered working pattern was implemented. Care workers told us the home manager was often not there, spent time in another location or at meetings. The home manager explained that three senior care workers were in place at Lavender Court, and after the previous manager left, these staff were given added responsibilities associated with their roles. This included for example quality assurance, training and monitoring the safety of medicines.

However, when we spoke with the staff, they told us they were not given any additional time to perform the tasks. They explained they were expected to instead perform the tasks by taking time out of people's

personal care process. The care workers we spoke with agreed that these roles assigned by the home manager were important. The service did not though give the workers the knowledge or skills to undertake checks in the quality of care. When we asked, there were also no regular in-house meetings with staff or records that showed any issues related to people's care, staff training and other management or leadership issues were discussed amongst the Lavender Court team.

Accidents and incidents were recorded by staff and reviewed by the deputy manager and home manager. We looked at a selection of records from 2016. We found care workers had used the service's existing form to document necessary details. However, when we were shown the folder, we were told the accident forms were previously unorganised. They were found when care workers were required to tidy up and reorganise the staff office. One care worker we spoke with explained they had gathered the accident forms together and placed them in a central place. This ensured that all of the located forms were together for the purpose of tracking. However, in the selection we viewed from the latest accident records, no management or other staff member had reviewed the records. The section of the forms was blank in every instance. Staff we asked were unsure why incident records were not reviewed by the home manager. The failure to review the incident reports meant that the service did not adequately assess or mitigate risks, or attempt to prevent reoccurrence of the same event. In the incident reports we found one person had spilt a hot drink on themselves and another person had experienced regular falls. Care workers had identified the people had risks to themselves. However, people's risks were not acted upon by management.

At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. This meant the provider ensured that confidential personal information was handled with sensitivity and complied with the legislation. Providers are also required to display their employer's liability insurance certificate and a poster from the Health and Safety Executive (HSE) about workplace law. We found neither of these were on display for staff. We found the HSE poster rolled up on top of a cupboard.

We asked a care worker and the home manager about any types of audits or checks the service completed to ensure the quality of care. We named a few of the most common types of audits that care homes might conduct on a regular basis. For example, we asked if there were care file, medicines, infection control or health and safety audits. At the inspection, no evidence could be produced that the service assessed, monitored or improved the quality and safety of the care provided.

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

Providers are required to comply with the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity. The management were familiar with the requirements of the duty of candour and were able to clearly explain their legal obligations in the duty of candour process. The service did not yet have an occasion where the duty of candour requirements needed to be utilised. At the time of the inspection, the service had a duty of candour policy in place. The policy clearly point out the steps for the management to follow if the duty of candour requirement was triggered.

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 Registration Regulations 2009 (Schedule 3) Statement of purpose The registered person failed to keep the statement of purpose under review, and revise the statement of purpose. The registered person failed to provide written details of any revision to the statement of purpose to the Commission within 28 days of any such revision.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 Registration Regulations 2009 Notifications – notices of change The registered person failed to give notice to the Commission, as soon as it was reasonably practicable to do so, that a person other than the registered person carried on or managed the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person failed to notify the Commission without delay of certain incidents which occurred whilst services were provided in the carrying on of the regulated activity, or as a consequence of the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 9 HSCA RA Regulations 2014 Person-

personal care	centred care The registered person did not design care or treatment with a view to achieving service users' preferences and ensuring their needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. The registered person failed to adequately assess the risks to the health and safety of services users of receiving the care. The registered person failed to do all that was reasonably practicable to mitigate any such risks. The registered person failed to ensure the premises used by the service provider were safe to use for their intended purpose and used in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and others in relation to the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving the service). The registered person failed to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the

purposes of continually evaluating and improving the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent and skilled and experienced persons were not deployed. Persons employed by the service provider in the provision of the regulated activity did not receive appropriate support, training, professional development, supervision or appraisal as was necessary to enable them to carry out the duties they were employed to perform.