Karelink Limited

Lavender Court

Inspection report

556 - 558 Wolverhampton Road East
Wolverhampton
West Midlands
WV4 6AA

Tel: 01902621721

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Our inspection took place on the 31 May and 01 June 2018. The inspection was unannounced. This was the first inspection of the location since a change of provider so this will be the first rating for the location under the management of Karelink Ltd. We did receive some concerns from commissioners and other professionals about the care people received prior to our inspection and this had influenced the timing of our visit. We looked to see if these had been addressed at the inspection.

Lavender Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Lavender Court accommodates a maximum of 49 people in one building. The provider accommodates people living with dementia, poor mental health, physical disabilities and sensory impairments. At the time of inspection most people living at the home were older people, although a service may be offered to people under retirement age if appropriate. At the time of the inspection there were 30 people living at Lavender Court. The building was originally built as a care home and there are a number of adaptations to accommodate people who receive personal care with nursing. The building provides all single room accommodation and there are a number of communal living areas.

The 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. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection the location did not have a registered manger although a manager had been appointed and had applied to be registered with CQC. The acting manager and the regional manager were available throughout our inspection.

People and their relatives told us they were safe at the home. We found there had been improvement to the systems in place to identify risks to, and safeguard people. Staff were aware of these systems. People said there were sufficient staff but there were occasions where responses to people's requests for attention were delayed. People's medicines were managed in a safe way, with minor exceptions relating to recording. We found the environment was clean, was well maintained and people were protected from cross infection. We saw the provider had learnt from recent concerns raised from commissioners and was improving the quality of the service.

We found people's rights were promoted, and their consent consistently gained by staff. Systems for the assessment of people's needs had improved and ensured any risks due to people's health were identified and responded to, with access to health care services as needed. Staff were well supported and had received training and had further training planned appropriate to the skills they needed for their job. People had healthy diets and sufficient drinks although we found the meal time experience could be more relaxed,

this recognised by management. The provider, whilst having improved the presentation of the environment, said they now wished to make the home more 'dementia friendly'.

People were supported by staff who were kind and caring, and were seen to treat people with dignity and respect. We saw people's independence was promoted. People and their relatives were able to express their views and make choices regarding their or their loved ones daily life. People's contact with their families was encouraged by the provider.

We saw people, or their representatives were involved in planning their care and staff showed an understanding of people's needs, likes, dislikes and personal preferences. People had access to some activity when they wished to participate. The management had identified, based on people's feedback this was one area where they needed to improve, and they were employing dedicated staff to provide more activities. People were confident any concerns they raised would be listened to and addressed. Systems to enhance how the provider responded to people's needs at times leading up to and after the end of their life were in development.

Management were said to be approachable by people, relatives and staff and we saw they were accessible. The management understood what they needed to do to comply with the law and were open and honest about challenges they faced. The acting manager said they aimed to ensure people have on-going, consistent and appropriate care. We found systems for monitoring the quality of care were in place, or being developed. The provider had taken on board advice from external agencies such as commissioners to assist their learning.

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

There were sufficient staff but responses to people's requests for attention were sometimes delayed.

People received their medicines in a safe way and recording of medicines administration, with minor exceptions was safe.

People told us they felt safe at the home and there were systems in place to identify and respond to risks. Systems were in place to safeguard people and management and staff were aware of these.

The provider had systems in place to ensure a good standard of cleanliness was maintained and people were protected from cross infection

We found the provider learnt from incidents, events and feedback from others to improve the service.

Is the service effective?

Good

The service was effective

People's rights were promoted, and their consent sought by staff.

The assessment of people's needs ensured any risks due to their health were identified.

Staff felt supported and received training, or had training planned which would be appropriate in developing their skills for the job.

People were supported to maintain a healthy diet and good fluid intake, although the meal time experience could be more relaxed.

People were supported to access the health care they needed.

Steps had been taken to improve the environment, and there

were plans to continue this to make the home more 'dementia friendly'.

Is the service caring?

Good

The service was caring

People were supported by staff who they said were kind and caring.

Staff treated people with dignity and respect.

People's independence was promoted.

People were supported to express their views and make choices regarding their daily living.

People were supported to maintain links with significant others.

Is the service responsive?

Good

The service was responsive

People, or their representatives were involved in their care planning.

Staff had a good understanding of people's needs, likes, dislikes and personal preferences with regard to likes and dislikes.

People were able to engage in some activities if they wished and the provider was looking to develop these with newly recruitment staff.

People were confident that if they raised a complaint they would be listened to.

The provider was looking at developing systems to enhance how they responded to people's needs at the end of their life.

Is the service well-led?

Good

The service was well led.

The management team were well known to people, relatives and staff, who said they were approachable.

The manager and regional manager understood their legal responsibilities and were open and honest about the challenges they faced in further improving the service so people were safe

and received good quality care.

Robust systems for monitoring the quality of care were in place, or being developed in conjunction with advice and support from outside agencies.

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 prompted in part by concerns we received from commissioners and other professionals that had been involved with the service since the new provider took over management of Lavender Court. These concerns included information that indicated people were at risk of illness or harm due to the poor management of the risks presented by people's health.

There had been an investigation carried out by the local safeguarding team as there had been a high number of deaths reported between December 2017 and February 2018. While there was no identified causal links between the deaths there was learning identified for the provider by the safeguarding team. These included concerns about the way people with choking risks were fed, how diets were supplemented, fortified and how people's skin was protected from pressure damage. In addition poor management of nursing care and gaps in staff training were found.

This comprehensive inspection took place on 31 May and 01 June 2018 and was unannounced.

The inspection team consisted of one inspector, a specialist professional advisor [SPA] who was a registered nurse and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service

We reviewed other information that we held about the service such as notifications, which tell us about incidents which happened in the service that the provider is required to tell us about. We also spoke with other agencies such as commissioners and safeguarding teams. We used this information to help us plan our inspection.

We spoke with six people who lived at the home. A number of people living at the home were not able to clearly express their views so we spent time observing how staff provided care for people to help us better

understand their experiences of the care and support they received. We carried out Short Observational Frameworks for Inspection (SOFI) to observe the people's experience of life at Lavender Court. We spoke with nine visiting relatives, the regional manager, the acting manager, two nurses, a senior carer, three care staff, a domestic and a cook. We spoke with one health care professional during the inspection. We reviewed six people's care records; 11 medicine administration records (MARs) and three staff files. We also looked at records relating to the management of the service including quality checks and audits.

Requires Improvement

Is the service safe?

Our findings

People who lived at the home said they felt safe. We saw people were assisted by staff in a safe way, for example when assisted to stand. One person told us, "I feel safe." People's relatives told us they had confidence in staff and felt safe leaving their loved ones at the home. One relative told us their loved one "Wasn't safe at home, I couldn't manage any longer. It has been such a relief and I can visit any time. I usually come three days a week and help to feed [the person] as they need help and will eat for me. I feel happy when I am here and happy and confident when I leave". Staff were aware of how to support people in a way that minimised risks to their safety. For example a nurse told us about a person who was prone to moisture lesions. We saw a care plan was kept in place as this can recur. The nurse told us; "At present their skin is intact but (the person) has bowel movements which can irritate again. (The person) has barrier creams to minimise the risk". This meant this person's skin was checked to ensure any recurrent risks of skin break down were addressed.

People expressed mixed views about staffing levels, although concerns related more to staff's response times to the call system, as opposed to whether there were enough staff. One person told us there was enough staff and said when they needed assistance, "The staff come quickly". Another person said, "It often takes fifteen minutes for the bell to be answered. When they are short of staff they will call in someone to replace if possible. It isn't always possible". The person said this did not put them at risk but was frustrating for them. They discussed this with the acting manager at the time, who said they would resolve this issue and asked the person to report any reoccurrence to them. We also saw one person who was waiting for staff to re position them so they were comfortable, as they were unable to move themselves. One of the inspection team asked a senior nurse if a member of staff was coming to the person and they said to us, "I don't know anything yet, I have just come on duty and I have no staff". Following this the person wanted assistance to the toilet so rang the call bell. We observed it was 13 minutes before the call bell was answered by staff. We raised this with management who said they would consider auditing staff's response times to call bells. We saw a number of other occasions where requests for assistance from people were answered quickly by staff however. Most staff told us staffing levels were usually sufficient, one telling us, "Most of the time it's pretty good staffed". They told us there was only the odd occasion where an additional member of staff may be helpful, but felt there was sufficient staff to keep people safe. Staff and the acting manager confirmed there was minimal use of agency staff, but when agency staff were used, it was staff familiar with the home and people living there. Care staff said the availability of ancillary staff was a benefit as this freed them up to be able to focus on people's care, rather than cleaning, laundry or food preparation. In addition the presence of a receptionist meant any visitors would be quickly responded to without distracting staff from their duties.

We found the provider's safeguarding and whistleblowing policies reflected local procedures and contained relevant contact information, with related information seen on display in the home. Staff demonstrated a good awareness of safeguarding procedures and knew who to inform if they witnessed abuse or had an allegation of abuse reported to them. The management were fully aware of their responsibility to liaise with the local authority if there were any safeguarding concerns; this was demonstrated by alerts that had been raised with the local authority safeguarding team and ourselves. We did, however, find a medicine error we

identified had been recognised by a nurse and not reported to the manager. Whilst there was no perceived harm to the person as a result of this, the lack of escalation was a concern. We raised this with management who immediately referred this to the local authority as a vulnerable adult alert, and said they would investigate why the issue was not escalated by the nurse. There had been a number of safeguarding alerts raised since the provider took over the running of the home, although we saw that the management team had taken the learning from these incidents seriously and were working hard to address, or had already addressed them.

We heard from commissioners prior to our inspection that risks to people 's health were not managed well which had left people at risk of harm on occasions; for example commissioners found there was poor assessment of risk in respect of pressure injury prevention. The management fully acknowledged the difficulties they had encountered when the provider took the service over and we saw work had been completed to improve risk assessments so risks to people's health were identified, and staff were aware of these. For example: we saw a new recording system was in place that included more detailed and informative risk assessments. These documents were individualised and provided staff with information on any risks and guidance on the support people needed to manage these; for example we saw there was clear detail for staff as to how to reduce the risks of people choking, and staff we spoke with were fully aware of the detail within the risk assessments. In addition we saw risk assessments in respect of the management of pressure injury prevention had improved, with no one living at the home having any pressure injuries at the time of our inspection. We found some limited gaps in some risk assessments; for example we saw one person supported to move in a way not referenced on their risk assessment for mobility. How the staff managed the transfer was safe and showed they had a good understanding of how to ensure the person's safety. This indicated the risk assessment needed updating, rather than a change in practice. The acting manager said they would reassess this person's needs in respect of any moving and handling risks.

We found a robust recruitment and selection process was in place that included a number of checks to confirm the staff member's suitability to work with vulnerable adults; for example last employer references, health checks and exploration of their working history. All staff had been subject to criminal record checks before starting work at the service. These checks are carried out by the Disclosure and Barring Service (DBS) and helps employers to make safer recruitment decisions and prevent unsuitable staff being employed. We saw checks were also carried out on nurse's professional registrations (PINs) with the Nursing and Midwifery Council (NMC) to ensure these were current and there were no restrictions of their practice.

We found overall that systems were in place to consistently and safely manage people's medicines. People told us: "Staff bring my eye drops, tablets and powder, I get them on time, I always get them". The provider had told us of some concerns they had identified with the management of controlled drugs prior to the inspection, following which they made changes. When we looked at how the provider managed people's controlled drugs we saw these were safely managed. We looked at how other medicines were managed and found some issues with recording. Following discussion with management we resolved some of these discrepancies although as previously mentioned we were concerned one error had not been reported to the management by a nurse. In addition one medicine given covertly was being crushed, without advice having been sought from a pharmacist as to whether this would make it less effective. Following the inspection the manager did consult with a pharmacist and subsequently found crushing the medicine would have no impact. Observation of nurses giving people their medicines showed administration was carried out in a safe way, with consideration of people's choices as to whether they wanted to take their medicine. We also saw people were given the time and assistance that may be needed to take their medicines in a safe way.

We found the provider had systems in place to ensure a good standard of cleanliness was maintained and people were protected from cross infection, this included suitable policies and procedures. One person we

spoke with told us, "It's nice and clean now". Staff we spoke with understood the need to maintain good infection control, and we saw they consistently used disposable gloves and overalls as needed. Staff we spoke with understood the need to maintain good infection control and said they had received training. The environment presented as visibly clean and on the two days of our inspection we only noted one unpleasant odour that was quickly resolved.

We found the provider learnt from incidents, events and feedback from others to improve the service, for example the Regional Manager told us how they had learnt from investigations carried out by themselves and other bodies into incidents that had occurred at the home. They told us how information from, for example the Clinical Commissioning Group (CCG) had been very useful in helping identification of where improvements were needed to reduce risks to people. An example of this was the poor record keeping that the regional manager told us had been in place, which they decided to update through the use of computer based records that were easier to access (all staff had mobile devices to access). They understood the link between the poor information that had been in place and increased risk to people, hence the reason they had prioritised this change.

Good

Is the service effective?

Our findings

We saw staff promoted people's rights, to choice for example, during our inspection. One person told us, "I can do just what I want". They went on to tell us there were no restrictions beyond those where they felt their health limited them. We saw people were free to move around communal areas as they wished. The management also told us they promoted awareness of the human rights act within the staff team, and staff we spoke with had an understanding of what this meant in respect of how they provided support to people.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The acting manager told us only one person was subject to a DoLS and there were conditions in place. As the person's health had changed since the DoLS was granted we questioned if these conditions were now appropriate. The person based on what we saw, were told by staff, and from records no longer presented challenges to staff. We discussed this with the acting manager who said they would ask the local authority DoLS team to review the conditions. The manager told us a number of other applications had been submitted to the local authority for approval but these were yet to be agreed. We saw people's 'best interests' were considered when decisions were made about their care. For example, one person was administered medicines covertly and we saw a best interest decision was made with the person's GP, with any non-essential medicines being withdrawn. The management told us when they involved relatives in the decision making process they were conscious of the need to ensure that any relatives making decisions on behalf of their loved ones had the appropriate legal powers to make decisions about their health, for instance an agreement giving them lasting power of attorney.

Following concerns expressed by visiting professionals as to the quality of assessment of people's needs (for example not consistently identifying risk to people), prior to our inspection, the provider purchased a bespoke electronic system for the management of assessments and care planning. The format of these assessments reflected the requirements of the law and the equalities act, for example assessments and reviews explored the impact of people's health and background and how this impacted on their care requirements. Management were open that the updating of assessments from the old to new formats was on going, although we saw most assessments and care plans were now electronic. We saw the new assessments were more comprehensive than previous ones, and these captured people's individual needs in detail. We saw staff had mobile phones when arriving on duty, and they showed us how this allowed them access information about people's needs, or record care interventions with people. This meant if they were unsure of a person's needs they could access information quickly. Staff told us they found this system useful, and had received training in its use. We saw the electronic system alerted the staff when assessments or care plans needed review, as we noted some care plans had been automatically identified as needing review on the day of inspection.

We saw staff provided care for people in a way that showed us they were well trained. One person told us "This is definitely a nice place all staff are handpicked, they have a full background of dementia and they are all skilled up with it, you can see". Staff told us there were some areas where they felt they would benefit

from further training, for example in respect of dementia care. Whilst staff showed some insight of what was important when caring for people with dementia, they recognised they would benefit from further training in this area. The regional manager showed us evidence that dementia training was booked for some staff in the near future. There had been some concerns expressed by other agencies as to the training staff had received prior to our inspection, and the regional manager said when the provider took over the running of the service these concerns were valid. They told us how they had prioritised training for staff in the most important areas, for example moving and handling people, where the majority of staff had now been retrained. Observation of staff on a number of occasions showed they carried out safe moving and handling techniques when supporting people which demonstrated the training had been effective. We saw the provider's training plan and this showed most staff had received training in those areas related to people's safety, although where not this was identified and we saw evidence of planned training in the near future. Training in others areas of key skills, for example: catheter care and dementia care, was seen to have been planned.

Staff recently employed had participated in an induction process that included elements from the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of people working in the care sector. We spoke with staff recently employed and they confirmed they were well supported during their induction. One staff member said, "I was left shadowing three days, as supernumerary (additional to usual staff numbers). I watched things going on and how things were done". They also said they had a senior staff member that mentored them and they had sufficient induction support. Staff told us they had recently received supervision and felt well supported by senior staff and the acting manager. Staff told us they had recent appraisals and added, "I can get support from (the manager) or (Regional Manager)", "Sometimes a bit hectic, If I get stressed out they (management) will say go and get a cup of tea, have time out".

People told us they liked the food they were offered and had a choice., People's comments included: "If something is on the menu I don't like the chef comes up and gives me a list of my ready meals in the freezer and I choose what I want, it suits me fine I don't like bland food", "Foods alright, fish and chips today and on Sunday a roast, sprouts I always ask for and chicken drumsticks, they have some more on order for me at the moment" and "You should have seen (another person) when they came here two months ago they hadn't eaten for ages. In just two months they are coming back to their old self now." We found staff were able to tell us what people's dietary likes and dislikes were. We spoke with the cook who told us that options for people with different cultural needs were available; for example, vegetarian and Asian meals. Where people needed a pureed diet, as assessed at risk of choking we saw these were presented in a way that was appetising and in accordance with the speech therapist's advice. We saw people had assistance with eating from staff as required. The cook told us they were aware of people's likes and dislikes and showed us documented information about people's specific dietary needs; for example soft and pureed diets. We spoke with a visiting health professional who confirmed they had visited the home in the past to give staff guidance in respect of some specific individual's dietary needs, and had returned to follow up on how staff were progressing with the support they provided. From sight of people's records we saw that people's diet and fluid intake was well monitored. Records confirmed people had a good food and fluid intake. Staff were aware, when people were at risk of choking how to prepare food to ensure this risk was minimised.

We observed people's dining experience (in the main dining area) and we found this to be very noisy with many people in the room. There was only one dining room in use at the time of the inspection, although people did tell us they had the choice to eat in their bedrooms if they wished. Some people living with dementia required different levels of support and we saw there was enough staff to assist, but this did contribute to the perception of a very busy environment. We discussed this with the acting manager, who told us they recognised this was an issue and was discussing possible changes with the provider as they said

they aimed to make meal times were more relaxed, and better for people living with dementia. The provider confirmed with us after the inspection that they were looking at ways to improve the environment so as to address this issue, with suggestion from the provider there would be structural changes to improve the dining space available for people in the dining area.

People were supported to access the health care they needed. A person said, "I can see the doctor when I want, dentist I can have if I need them and the chiropodist comes in". Staff told us they monitored changes in people's health and would contact appropriate healthcare professionals where needed, this seen to reflect what we saw recorded in people's records.

The home was had been recently redecorated which included an upgrade to the lighting meaning the environment was overall far lighter and more inviting than previously. We heard positive comments about the improvements, for example one person said how comfortable their new mattress was adding, "It's a good bed now" and, how they liked their redecorated bedroom. The Regional Manager told us about numerous changes they had made to improve the environment, such as redecorating (we saw corridors were far lighter) fitting new lighting, removing furniture so there was more space and replacing furniture. The management recognised the environment needed further improvement to make it more 'dementia friendly' though, for instance they told us more appropriate signage was needed and points of interest that would allow people easier identification of areas. This was said to be the next step in the home's refurbishment, as redecoration was only completed recently. Lighting had been changed to minimise shadows to benefit people who experienced Sun downing Syndrome, although the regional manager was aware and was looking at ways to improve lighting in one lounge that did not have as much natural light.. Management told us those people experiencing Sun downing Syndrome were offered time in areas of the home that were lighter later in the day with their agreement. Sun downing Syndrome is a symptom of Alzheimer's disease/dementia. It may present as a person becoming more anxious or challenging to staff in conjunction with changes to light, usually later in the day.

Good

Is the service caring?

Our findings

People told us staff were caring one telling us, "Everything here is lovely, the staff are lovely and they talk to you and I like it here". Relatives we spoke with were also complimentary about how their loved ones were cared for with comments such as, "The staff are lovely, they are like a breath of fresh air", "It couldn't be better, they're so kind caring and supportive. Mum always looks well, she is clean and we know she is being looked after. They love her and take care of her", "Mum always smiles when she hears their (staff) voice which is always a good sign", "It is brilliant here, the staff are so lovely and consistent which makes such a difference".

We saw people were comfortable with staff and interactions between staff and people were friendly. We saw staff would talk to people, and tried to understand what was important for them. For example we saw one member of care staff asking someone when they had sat them in a chair, 'Is it not comfortable, do you prefer to sit like this?' in response to their physical signs of discomfort. After the person indicated they wished to reposition staff helped them in a safe and unrushed way, explaining what they were doing throughout. We saw a caring approach was also maintained by ancillary staff, for example they would stop and chat with people whilst completing other requested tasks, in a very relaxed and friendly way. We saw a number of occasions where people were smiling and shared jokes when staff spoke with them.

We saw people's privacy and dignity was promoted. For example when people were supported in communal areas, and this had potential to compromise their privacy and dignity staff were seen to use a portable screen. We saw when personal care was provided in bedrooms the door to the room was kept shut, and we saw staff knock doors before entering, also waiting for confirmation they could enter from the person inside. Staff told us they recognised the importance of promoting people's privacy and dignity for example one said, "You keep doors closed, curtains closed, cover people with a towel when offering personal care and tell them, I'm doing this, and I'm doing that."

We saw staff consistently asked people for their consent before; for example providing personal care or support. Staff told us that they would do this for everyone, and where they were not able to verbally communicate they would look for non-verbal signs of the person's agreement/disagreement before proceeding, as we saw when observing staff interactions. Some people did not speak English, and we found there were staff employed who could speak other languages. There were a number of people who spoke Asian languages and we saw the staff rota was planned so there was always a member of staff on duty that could speak these languages. We saw these staff called to communicate with people when needed. Staff also told us, "The tone of voice we use is important".

Staff we spoke with had a good awareness of people's likes, dislikes, individual preferences and understood the importance of respecting people's rights. For example one person told us how they were aware of the importance of not shaving, or cutting one person's body hair and the impact this could have for their emotional well-being. Whilst this would not be a task they said they would normally do, it was an important consideration if the person was at any point to have surgery, and would be important information for relaying to other services.

We saw people were encouraged to remain as independent as possible. People were able to move freely within the home and we saw staff encouraged people to be independent, for example encouraging them to feed themselves where able or walk with support and encouragement. A staff member told us they encouraged a person with dementia to drink independently. They said the person, "Drinks better with a coloured cup, better than a clear", and they understood this was due to the person living with dementia.

We saw there was information on display in the home for people about a local advocacy scheme and the management were aware of when requesting an advocate would be appropriate; namely where there was a need for a person to have additional support. An advocate is a person who seeks to ensure that people are able to have their voices heard on issues important to them. No one was receiving support from an advocate at the time of the inspection but we did see that a number of relatives told us that they 'advocated' on behalf of their loved one and would raise any issues with the staff.

Visitors told us there was no restriction on visiting the home. We saw people visiting were consistently greeted in a friendly way on arrival. One relative said "Whenever you come whatever time of day they make you welcome they always come and talk if they have time". Staff told us they recognised the importance of privacy when people saw their relatives one telling us, "We will take visitors to the middle lounge (as we saw) or ask if they want to go to bedroom and then take them to their room". We also saw an unused bathroom was being converted to a meeting room, which management said could be used if privacy was required for such as reviews of people's care.

Good

Is the service responsive?

Our findings

We saw people, or their representatives were involved in their care planning. Where people had limited capacity staff told us they would look to observe people's reactions or response to situations, this information then captured and used to inform their plan. In addition there would be discussion with the persons' relatives or representatives to capture what was important for the person. A relative told us, "They always let me know what is happening, They tell me if they change the care plan; they ring me in the night if I need be to let me know anything and keep me up to date". Another relative said, "They discuss the care plan for my relative and explain why if it has to change". We saw in the provider's action plan the provider had purchased some new lap tops so that discussion with relatives could be uploaded to the electronic care plan system at the time of discussion, to ensure information was available to all staff as quickly as possible.

We reviewed people's assessments and care plans and based on concerns about their accuracy from other agencies prior to our inspection and noted there had been improvement. The operational manager stated that there was still work to do and they were updating all assessments and care plans to ensure the information they had about people's needs was accurate and up to date. We found they detailed people's individual needs and contained information on people's requirements, likes, dislikes and preferences. We found some limited exceptions, for example where there was some update needed in terms of how staff would response to a person having seizures. This person's care plan was updated during the inspection and when we spoke to staff we found they already had a good knowledge of the person's needs and how they should respond if they had a seizure. We did find the person's seizures had been monitored and the manager had responded by referring the person to their GP to have a review of their epilepsy medicines.

We saw staff offered people choices on numerous occasions during our inspection, and staff waited to receive a response before providing support. We saw staff informed people what they were doing whilst providing support so giving them the opportunity to comment or respond. We saw the manager responded to comments people made to us, but had not raised with staff, when this was fed back to them. People also told us they were consulted about moving rooms, one when it was to be redecorated, and another as they wished to move to a room in another area of the home. Both told us this only happened with their agreement. We discussed people's care with staff and they demonstrated they had a good understanding of people's needs, preferences and requirements, as detailed in their plans. Staff showed us when they were unsure of what a person's needs were how they used the portable mobile device they carried with them, this so they could access a summary of the person's care records and clarify their knowledge of the person's care plan. They were able to demonstrate that they could do this quite quickly, and we saw critical information in respect of whether people had a do not resuscitate agreement could be seen quickly as it was denoted by a red dot on the landing page on the device.

We saw staff spent time with people talking and interacting with them, although we saw a few people were happy with self-directed activity. One person told us while they knew there were some activities they chose not to participate. They said, "Sometimes a little walk downstairs and back again, then have a read, and I have a radio". They said this was enough for them. We saw during our inspection the staff did look to find time to interact with people where possible and involved them in some activities, for example,

reminiscence, play your cards and ball throwing and catching. Where people were on bed rest we saw and heard that radios were at times playing in their rooms, with programmes reflecting a person's cultural preference. When possible staff would stop and chat with people, which based on their reactions was enjoyable. We saw this was all staff, not just care and nursing staff. The management told us they had heard from people and their relatives from a recent survey, as shown to us, that activities for people needed improvement. We saw comments in recent survey forms from relatives included, 'aware activities occur', 'not many activities/entertainment' They told us they were responding to this by employing a dedicated activities officer, who was due to commence working at the home in the near future. They told us they aimed to ensure activities for people were developed so they reflected the needs of people living at the home, for example people living with dementia.

We saw there was a complaints procedure on clear display in people's bedrooms and relatives told us staff would observe people's behaviour and expressions to monitor their views. People we spoke with mostly said they had no complaints, although said they would be able to raise any concerns if needed. Some people who raised some concerns readily agreed to have the manager involved in the discussion with them and the inspector, and were comfortable discussing these issues. One of these comments was in respect of staff response to call bells the other in regard to the banging of a door. The manager agreed to monitor the former (with an audit of staff response times to the call bells considered), the latter resolved at the time by the maintenance man. The provider had received a formal complaint earlier in 2018 and had responded in writing to the complainant in accordance with their complaints procedure. The provider investigated and in the response was open about where issues of complaint were a result of unacceptable practice and what they were doing about this. They also asked the complainant to contact them directly if they had further concerns.

We found the management had considered the need for improving how the service responded to people's end of life care and they were in the process of developing an end of life care plan format with reference to The National Institute for Health and Care Excellence (NICE) guidance which we saw to be to hand. While there were people living at the home who were poorly and on bed rest there was no indication that an end of life care plan was appropriate at the time of the inspection for these people. Although we did discuss with management the need to ensure people's or their family's views were captured where possible as to what they would wish to happen in the lead up to and after death, to ensure their wishes were respected at this difficult time. The management told us they had looked to pre-empt discussion with people sensitively on occasion although this had not been a subject people had been comfortable with. We saw anticipatory medicines were available for those people where health professionals had indicated there may be a change in the person's health. We also saw there were systems in place to monitor any pain people may be in and ensure pain relief was provided when needed.

Good

Is the service well-led?

Our findings

People and their relatives were, with few exceptions positive about the service provided to them at lavender Court. People told us, "It's alright, it's very good. (Staff) They are very good, nothing I would change now". A relative said" I feel as confident when I leave them as I do when I am here that they are taking the very best care of them. I have no worries at all leaving", another, "I had heard from residents that there had been a lot of changes in staff this year but they are settled now with permanent staff in place full time and little need of agency staff to be called in". We saw the last survey of people that used the service and stakeholders was in March 2018. We saw comments from relatives were positive overall and included, 'Friendliness and caring staff, kitchen staff, cleaners and laundry staff. Approachability of staff. Hard working staff on the whole', 'Staff always available', 'All of the staff are very welcoming and we feel we are part of dad's care'. We noted the questionnaire asked what do you think is the worst thing about the home? This drew some response that said the turnover of staff had been a concern and activities could be improved. These were issues the provider was aware of and in respect of activities was recruiting a dedicated activities co-ordinator. One respondent to the survey commented, 'The changes to staff and the upheaval of the physical decorating etc. However we feel it has been well managed.' We found the atmosphere in the home through the inspection was relaxed and calm.

The provider is required to have a registered manager to oversee the running of the regulated activities at lavender Court. At the time of the inspection the acting manager, who had been employed by the provider recently was not yet registered but had applied to us to progress their registration. Whilst the lack of a registered manager would normally be seen as a limiter on the rating for the domain 'Well led' we saw that the provider and acting manager had done all they could to address the issue, with the application with the CQC registration team. The manager was employed as a 'registered manager' for a care home previous to their recruitment by the provider. Despite having managed Lavender Court for only a matter of months the manager was able to demonstrate a good understanding of the service provided and the needs of people that lived there. They also understood the challenges that were presented to them, in light of previous concerns that had been identified by statutory agencies, and was positive that these would be addressed in order of priority. We saw, and were told by the regional manager that they were basing themselves at the home to support the manager, and move improvements forward before they would take a step back to a quality management role.

One person told us, "I can't recall (the manager's) name but they pop in and ask how you are and very often bring a cup of tea". We found the manager had a strong presence around the home. People living at the home and staff and residents appeared to know her well and she had a calming manner when out and about. We saw people were comfortable in their presence and two people we spoke with when raising some issues, were happy to involve the manager in the discussion. We spoke with staff and they felt very well supported by the management team.

The manager and regional manager understood their responsibilities. They were open and honest about the challenges the provider had faced in improving Lavender Court, and where they still needed to improve the service so people were safe and received good quality care. They were clear they would be open and honest

as required under their duty of candour, and we saw evidence that they had instigated discussions with people and relatives to ensure they were aware of changes, and acknowledged the need to say sorry if something went wrong. We also saw they understood the need to notify us of incidents that may occur, these having been sent to us promptly as required. The law requires the provider to display the rating for the service as detailed in CQC reports. As this is the first rating for the provider at this location this will not be required until this report is published, but we saw the rating for the service as given following our last inspection under the previous provider was clearly on display in the home.

The staff we spoke with told us they felt well supported by the manager and senior team. They told us, "The nurses are brilliant, they help us", "We can get support from (the manager) or (the regional manager)" and, "(management) now are easier to talk to". Staff also told us the directors visited frequently one person telling us staff, "We've had a couple of meetings with them, had a chat with when they came around, their phone number is on the staff room wall". Staff knew the provider's 'whistle blowing' policy and told us they would report concerns if not satisfied with any responses from the acting manager or provider. To whistle blow is to expose any information or activity that is deemed incorrect within an organisation.

The regional manager told us about new systems that had been introduced for monitoring the quality and safety of the service in place. While there was still some development of these needed (For example infection control audits and audits of some record keeping) we saw auditing of high risk areas had been prioritised. These included areas where concerns had previously been identified for example medicine, falls, and fluid intake and weight audits. This demonstrated the provider was developing systems to help identify risks that would help them learn and develop the service. For example we saw accidents and incidents were analysed for any trends and this informed how they planned some people's care so as to minimise risks. We also saw monthly checks of the premises that ensured the premises and equipment were safe, and any issues identified were addressed promptly.

The management said they worked in partnership with other agencies, with plans to develop this further with use of nurse practitioner visits once a week to review people's non-urgent medical needs. We heard from some external health professionals that the management was responsive and working with them to improve the quality and safety of care. The manager told us about the safety cross system which was suggested by the quality nurse advisor and was used to easily monitor people's health through for example monitoring their weights, incident of pressure damage to skin and fluid intake. They told us they had found this system very useful. Visiting professionals comments had been sought through the provider's survey and these were positive with comments including, 'I find the staff pleasant and helpful', and 'I have no concerns about staff or care provision now. Helpful cheerful, positive staff' and, 'The environment feels very positive since earlier visit in December 2017'.