

Compassionate Care Home Ltd

Lavender Lodge

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Lavender Lodge is a residential care home providing personal care to 20 people at the time of the inspection. The majority of people are living with dementia. The service can support up to 20 people.

People's experience of using this service and what we found

Systems were not always effective in ensuring people were protected from the risk of infection. Some parts of the home were not cleaned to a high standard.

Care was not always delivered in a person-centred way, although staff were observed to be kind and patient with people. A housekeeper was on duty mainly during the morning. In addition to their caring duties, staff were expected to undertake cleaning and laundry tasks, as well as planning activities with people. Two people told us they had nothing to do during the day except watch television. After the inspection, the registered manager informed us that there were planned activities, usually in the afternoons.

Medicines were managed safely. There were sufficient staff on duty to meet people's support needs. People were protected from the risk of potential abuse and harm.

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

Audits were effective in monitoring and measuring the service and identified areas for improvement.

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

Rating at last inspection and update

The last rating for this service was Good (published 2 February 2018).

Why we inspected

The inspection was prompted in part due to concerns we had received about the service with regard to staffing levels, and cleanliness of the home. A decision was made for us to inspect and examine those risks. We were also informed that people were got up very early in the morning by night staff, therefore, inspectors arrived at the home soon after 6.00am on the day of inspection, to see whether this was the case. When we arrived at the home, people were still in bed with their curtains drawn.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well Led sections of this full report. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection. We discussed the issues that were of concern during the inspection, and the provider has taken steps to address these. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lavender Lodge on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took into account the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified a breach in relation to safe care and treatment.
Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Lavender Lodge

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was undertaken by two inspectors.

Service and service type

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service which included concerns raised. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with three people who used the service. We spoke with five members of staff including the registered manager, the deputy manager, two care staff and the maintenance staff.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at the provider's medication policy, monthly quality assurance audits and testing for COVID-19 for people and staff.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- The inspection was prompted in part due to concerns raised by a whistle-blower in relation to staffing levels at the home, and the management of the risk of infection.

- We were not assured that the provider was using PPE effectively and safely.

All staff had completed training on the use of PPE and donning and doffing. However, some staff did not sanitise or wash their hands when moving clinical waste and nor did they always use disposable gloves. Observation of the medicines round showed the staff member did not routinely clean their hands between dispensing medicines and moving between people's rooms.

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some parts of the home were clean, but others, especially in bathrooms, were not. We found what looked like the remains of faeces on the shower seat and on a grab rail next to the toilet in a bathroom on the first floor. The floor in a ground floor toilet was not cleaned to a high standard, and the commode placed there looked old, with rusting wheels, which could not be properly cleaned. A new commode was in the first floor bathroom, but had not been unpacked or put to use. The stair lift seat had grime and dirt on it. There was one member of housekeeping (cleaning) staff on duty each day for four hours only, during the mornings. Care staff were expected to undertake cleaning duties in the afternoons and at night when housekeeping staff were not on duty.

- We were somewhat assured that the provider was accessing testing for people using the service and staff. Staff and people have access to regular testing. People undertook Polymerase Chain Reaction (PCR) testing every 28 days, although this was brought forward when one person tested positive for COVID-19 in hospital. Staff undertook Lateral Flow Device (LFD) tests at the start of their shift and a weekly PCR test. No-one had refused a test. However, staff do not always await the results of their LFD tests before working on the floor. This is not in line with government guidance. 'Care home COVID-19 testing guidance', August 2021, states, 'It is recommended that staff rapid lateral flow testing takes place before shifts start. Staff should not commence work before the result of their rapid lateral flow test is known.'

- We were somewhat assured that the provider's infection prevention and control policy was up to date. Infection risks to people had been assessed and were generally managed well, except for the issues noted above. The provider has a contingency plan in place in the event of an outbreak.

The provider had failed to ensure that systems were effective in preventing and controlling the risk and spread of infection. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We discussed the concerns identified at this inspection with the registered manager. They told us they

had taken on board our feedback and had spoken with the housekeeping staff.

- After the inspection the registered manager informed us of the actions they had taken. They had completed supervisions with staff who administered medicines to reinforce the importance of always sanitising their hands between giving each person their medicines. All staff trained in medicines management were subject to spot checks by the registered manager to ensure they administered medicines safely.

Staff were reminded of the importance of wearing PPE in line with guidance. Spot checks were undertaken to ensure this was done and that staff were using disposable gloves when moving clinical waste.

Maintenance work had been completed in the ground floor bathroom, to enable thorough cleaning by the housekeeping staff. A deep clean had been completed after our inspection, and another was planned. The hours worked by housekeeping staff had been increased so that additional cleaning could be completed. Staff were waiting for the results of their LFD tests before coming into contact with people living at the home.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse

- Systems were effective to protect people from the risk of abuse. Any incidents were recorded and reported to the registered manager by staff.
- The registered manager had a clear understanding of what constituted abuse, and made referrals to the local safeguarding authority as required. The registered manager also notified CQC of any cases of abuse or alleged abuse.
- Staff completed training as needed.

Assessing risk, safety monitoring and management

- Risks were identified, assessed and managed safely.
- We reviewed risk assessments in people's care plans relating to moving and handling, skin integrity, diet and nutrition, and risks related to particular health conditions.
- One person lived with diabetes and their care plan included triggers for staff to look for that would indicate they were unwell. For example, staff should monitor the person for signs of nausea or vomiting, sour breath, abnormal urine, and whether the person had drunk enough.
- No-one required a modified diet, although a referral was made to a speech and language therapist for one person, who recommended any liquids required thickening to a certain level.
- Environmental risks were monitored and audited safely. Hoists, and other moving and handling equipment, had been tested by an external contractor and were fit for purpose.

Staffing and recruitment

- There were sufficient staff on duty to meet people's needs.
- Staff acted promptly when people needed support.
- Four care staff were on duty during the day, and the registered manager or deputy manager. At night, three care staff were on duty. The registered manager told us they were considering an additional member of staff to work a shift between 7pm and 10pm, to support people when they went to bed.
- New staff were recruited safely. We looked at recruitment records for two staff. Disclosure and Barring

Service checks, which related to a person's character and whether there was any criminal record, had been completed. Potential staff had their employment histories verified and two references were obtained.

Using medicines safely

- Medicines were managed safely.
- Medication was managed through an electronic system. We observed a staff member checked each box of medicines, then scanned the QR code, so the system checked the medicine was for the right person. This helped to prevent any errors from occurring.
- Two people received their medicines covertly, that is, without their knowledge. Decisions had been taken in their best interests for these people to receive their medicines in this way.
- Medicines were ordered, administered, stored and disposed of safely.

Learning lessons when things go wrong

- Lessons were learned when things went wrong.
- For example, any incidents of potential abuse were reported as required. The outcome of any safeguarding investigation by the local authority was reported and shared with staff as reflective learning.
- One incident where two people were arguing with each other had been captured on the home's closed circuit television (CCTV) system in a communal area. The video recording was reviewed so that staff could understand what had triggered the argument, and how the people involved could be supported to prevent a similar incident from reoccurring. People and their relatives were aware that CCTV was in operation at the home.

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The inspection was prompted in part due to concerns raised by a whistle-blower, who told us that people were made to get up early in the morning, as there was not enough staff on duty at night.
- In response to the concerns we had received, the inspectors arrived at the home soon after 6am, to see how many staff were on duty and whether people started to receive personal care at that time.
- We observed that people were still in bed, with curtains closed, and some people had their bedroom doors shut.
- At 6.25am, we observed the night staff go into one person's bedroom. The person's light was off and their curtains were closed; the person was asleep. The two staff then woke the person up, without warning. We heard the person calling out in apparent distress, saying, "Mum, Mum, oh, oh, oh". We then heard one member of staff attempting to calm the person, who appeared confused at being woken-up. The member of staff added, "We definitely need three on of a night". The staff then spoke to the person in an encouraging way.
- We later learned that the person had a restless night and was awake for a large part of it.
- During the morning, we observed this person was dressed and sitting in an armchair in the hall area. The person was clearly very tired, as they were bowed over, with their head resting on an overlap table; they appeared to be asleep. Staff then suggested to the person that, as they were tired, they might feel better if they went back to bed. The person initially refused, but was then encouraged to have a lie-down and rest.
- We discussed this incident with the registered manager who agreed that staff had not been sensitive to this person's needs and had not delivered care in a personalised manner. For staff to provide person-centred care and not be task orientated is an area in need of improvement.
- We observed that some people had notices on their bedroom doors which stated whether they had a 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) notice in place. DNACPR relates to whether a person should be resuscitated or not if their heart stops beating. It is not dignified or appropriate to have DNACPR notices on display in this way. We discussed this issue with the registered manager who agreed they would think of an alternative way to share this information in a more discreet manner.
- We reviewed a range of audits that measured and monitored the care delivered to people and the service overall. The audits included accidents and incidents and health and safety. These audits were effective and any actions arising were identified and acted upon.

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

- The registered manager understood their responsibilities under duty of candour and explained, "If something happens to a resident, we contact the families, give support and think how we could improve".
- An example of when duty of candour had applied was shared with us. One person had fallen in their bedroom and sustained a minor injury. The person's relatives had been contacted about the incident. A sensor mat was then placed next to the person's bed so their movements could be monitored, and staff could react promptly and give the person support when the alarm sounded.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager demonstrated a clear understanding of their responsibilities and of the regulatory requirements. They explained they also had oversight of one of the provider's other homes, and were supporting staff there.

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

- Activities were organised by care staff and we asked people how they spent their days. One person said, "It's okay, there are limitations. There are certain things I would like to do, but can't. I do absolutely nothing. I'm stuck in the chair, so all I can do is watch TV. Staff are brilliant and so helpful". Another person told us, "It's nice. They're okay, the staff. I don't do anything. I sit here with my memories and I like the TV. I've no complaints".
- People were dependent on staff to provide meaningful activities. Concerns raised by the whistle-blower to CQC indicated that staff did not always have time to spend with people, in addition to providing personal care and some cleaning or laundry duties. We observed staff were kind and caring with people, but there was little for people to engage with if staff were busy.
- We asked the registered manager about activities at the home. They told us that all activities were delivered by care staff, and there was no dedicated member of staff to organise activities. The registered manager explained that music was played regularly, and added, "We have moments with the residents, where we might have a little dance or sing. Upstairs there is a white box which plays bird sounds and waterfalls. There are films for people to watch. There are activities each day, it depends what people want to do". We were told that staff engaged with people on some sort of activity every day, although we did not observe this happening on the day we inspected. After the inspection, the registered manager told us that activities usually took place in the afternoons. We were sent copies of activities that were planned at the home.
- Staff appeared happy in their work and treated everyone equally. People living with dementia can be at risk of social isolation and we observed staff were patient and kind in their interactions and did spend time with them.
- The home worked in partnership with others.
- GPs from a local practice undertook weekly rounds at the home to monitor people's health conditions and provide clinical support.
- Dementia UK provided free guides for staff to look at and learn about how dementia affected people. Staff also received training and support from an external contact who provided 'tool box talks' on dementia and communication.

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 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that systems were effective in preventing and controlling the risk and spread of infection. Regulation 12(1)(2)(h)