Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Lakeland View Care Centre

220-224 Heysham Road, Heysham, Morecambe, LA3 1NL

Tel: 01524410917

Date of Inspections: 02 July 2014
23 June 2014

Date of Publication: October 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Management of medicines	✓ Met this standard
Safety and suitability of premises	✖ Action needed
Requirements relating to workers	✓ Met this standard
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed
Notification of death of a person who uses services	✓ Met this standard
Notification of other incidents	✖ Action needed

Details about this location

Registered Provider	North West Care Limited
Overview of the service	Lakeland View Care Centre is situated on the outskirts of Morecambe. It is an old building adapted for use as a nursing home, with a number of lounge areas and outside decking. Accommodation is provided on two floors. Most rooms are single, with shared bathroom facilities
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 23 June 2014 and 2 July 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and were accompanied by a specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

This was a responsive inspection because we had received information of concern regarding this service. This related to poor care practises, concerns regarding the environment and high levels of agency staff working at the home.

The inspection team included two inspectors and a specialist adviser. We observed care and support, looked at care plan records, looked at safeguarding processes and the staffing levels within the home. We looked at the management of medicines, checked the suitability and safety of the home, and the recruitment practises in place. We looked at the quality monitoring systems the provider had in place. We spoke with visitors, relatives, staff and other professionals. We checked our systems to see if the provider had submitted notifications regarding incidents affecting people who lived in the home. We undertook a SOFI; this was because some people living at Lakeland view were unable to tell us about their experience of living at the home.

Information we gathered during the inspection helped answer our five questions. Is the service caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led?

Below is a summary of what we found. If you wish to see the evidence supporting our summary please read the full report.

Is the service safe?
We looked to see how the service kept people safe and protected them from abuse or the risk of abuse. All staff had recently attended specialist training relating to managing challenging behaviour and break away techniques. Staff were also issued with personal alarms so that they could summon assistance if the required it.

During our inspection we noted two people had facial bruising. When we spoke with staff and the management team, no one was aware of the injuries or how they had occurred. When we referred to the care plan records and incident reports related to these people, they lacked information to show us how these injuries had been sustained or what actions had been taken. This showed us that people were not safeguarded against the risk of abuse.

One of the resident`s received one to one staff support. This was provided to safeguard other people from the risks this resident posed to other people living in the home due to their unpredictable and aggressive behaviour. The staff providing support were taken from the staff complement within the home. The provider had no actions in place to improve the situation. This affected the care other people received and to the detriment of care delivery to other residents. Despite the increased level of staff support provided, during the inspection this resident assaulted a frail elderly person. We reported this incident to the Local Authority Safeguarding Team.

We looked at the suitability and safety of the environment. We saw that some refurbishment had taken place to improve the standards within the home. However we did identify several areas for action and reported this to the provider. There was a lack of oversight regarding the concerns we had identified. This posed a risk to people.

Is the service effective?
Lakeland View is a busy home, and we saw there were instances when in the large lounge when there was inadequate staffing to support people safely. During the inspection we saw some people were sat for long periods without any stimulation or activities provided to meet their needs. At times there was only one staff member in the lounge with up to 15 people to care and support.

We noted there was a sensory activity provided for a small group of people in one of the smaller lounges and in the afternoon a group activity in the lounge was organised. However in the large lounge we saw some people who were withdrawn, sleeping, or carrying out repetitive behaviours with limited staff support to offer assistance or distraction.

We looked at the recruitment and selection procedures in place to ensure people were supported by suitably qualified and experienced staff. In the staff files we saw evidence of pre-employment checks being undertaken. However the provider may like to note in one person`s file, not all the pre-employment checks undertaken were robust. The manager told us it could be difficult to obtain references but told she would ensure a more up to date reference was in place. This would support the provider to uphold robust recruitment processes for the safety and well being of people living in the home.

Is the service caring?
We observed staff to treat people with respect and dignity. Staff were patient, kind and caring with people. Some staff told us they had worked at the home for a long time, and we saw staff had formed positive working relationships with people they supported. We saw some good practice, where people were supported sensitively and with respect.

We spoke with some people living in the home and some relatives. Relatives we spoke with told us they were happy with the care at the home. One relative said, "They have done well for him. They settled him down as he was agitated. They have a lot of time for him." They told us they mainly see activities in the afternoon. A second relative told us, "He seems to have settled in and they have been absolutely marvellous. They are very

patient with him and I couldn`t think of him being anywhere else." They added "I think these guys do a marvellous job." A third relative told us, "I can always talk to any of the staff if I need to. They do a good job. They'll always tell me if something's happened or he's unwell."

Is the service responsive?
Records of accidents, incidents and behavioural incidents within the home were not being accurately recorded, reported or appropriate action taken to protect people from the risks posed to them. Although we saw there were some incident records, we did not see incidents were effectively managed. We noted there had been four incidents involving one resident over the past week; however the records showed us that only one incident had been recorded. This meant the frequency and severity of incidents were not being highlighted and so measures to keep people safe had not been considered. This put people at risk.

During our inspection we noted two people had facial bruising. When we checked their records we could not see that any actions had been taken to safeguard these people from harm. Two care plan records we read did not give any adequate explanation for these injuries.

Is the service well led?
Although the management team had a range of systems in place to monitor the quality of the service we did not see evidence they were being effective. At a senior level, the management team were not aware of the severity and frequency of some of the serious incidents taking place within the home. Staff concerns were not always being reported appropriately so that action could be taken to protect people, staff and others from risks posed to them. Records of accidents, incidents and behavioural incidents within the home were not being accurately recorded. This showed us the risks posed to people were not being effectively managed.

Notifications regarding serious incidents and injuries to people and reporting safeguarding concerns were not always being completed and reported to the appropriate authorities including the Commission. This situation meant that no action by outside agencies had been able to be taken to protect people from harm.

There was a new manager in post who had submitted a registered manager`s application to the Commission.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 19 August 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We will check to make sure that action is taken to meet the standards.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not experience care, treatment and support that met their needs and protected their rights.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at this outcome because we had received concerns regarding institutional care practices within the home. The home was fully occupied with thirty three people currently living at Lakeland View. We looked at a sample of care plan records, observed the care and support people received, talked with people and spoke with relatives, visitors, other professionals and staff. We did this to give us an understanding of how people`s care was being managed.

Many people living in the home had limited verbal communication and understanding and were not able to converse with us easily. We saw and heard some good practice where people were supported sensitively and with respect. Staff appeared to be very caring and showed they had a good rapport with people they supported.

We saw there was a timetable of activities planned and on display. During our inspection a small group of people were supported with sensory activities in the second lounge area. In the afternoon the activity co ordinator supported a group activity in the large lounge. We also read detailed activities recorded in people`s care plan records. Activities available included the sensory room, colouring, music, hand massage and visits from a PAT dog (dogs for therapy). Outside entertainers also visited the home.

Although there was a large staff team on duty, the deployment of staff to meet the diverse needs of people was not always apparent. There were instances when in the large lounge there was inadequate staffing to support people safely and to provide meaningful activities. At times there was only one staff member in the lounge with up to 15 people to care and support. During the morning we saw people in the main lounge were left sitting unoccupied for long periods. We saw people who were withdrawn, sleeping or carrying out repetitive movements with limited intervention from staff to offer assistance or distraction.

During our inspection we observed staff transferring people from their wheelchairs, and the use of hoist equipment. Sometimes this was not always carried out safely. We discussed this with the manager who told us she had provided guidance to staff during the morning of our inspection to correct some of their practice. She told us she would not hesitate to correct poor practice. We did later observe a member of staff correctly provide support when transferring someone from their wheelchair.

One person we met spent long periods sat on a sling in their arm chair. A sling is used in conjunction with a hoist when people require moving and handling. The manager told us the person was intolerant to the level of moving and handling required to remove the sling. We asked if there had been a recent review of this practice by an occupational therapist. We were told that a review had not taken place, but would now be arranged. This would ensure current care practices met the person`s assessed needs.

We saw that care plan records were available electronically and also in hard copy files. They were very clearly written. We saw evidence of a full range of comprehensive risk assessments for people to ensure their safety and well-being. There was evidence documented of working in partnership with a range of health care providers such as speech and language therapists, district nurses, GPs, consultant psychiatrists, pharmacist and a nurse consultant (specialist in wound care). We saw evidence that care plans were reviewed regularly. We read where changes were required the care plan had been updated. Care plans reflected holistic care provision that included understanding the emotional needs of people, as well as their mental, physical and social health needs. A visiting professional told us, "We work well with the nursing care liaison teams and medication monitoring team. We can contact them anytime. We all work well together."

Most care plan records we looked at had all the necessary information to support people effectively. Most records showed strategies for managing behaviour that challenged. However one resident was receiving one to one support from staff. This was provided to safeguard other people from the risks this resident posed to other people living in the home due to their unpredictable and aggressive behaviour. We looked at this resident`s care plan we saw it identified there were risks of harm to others. However this information did not identify whether these risks were towards other residents or staff working within the home. Despite there being regular reviews, since January 2014 this resident`s health and episodes of aggression continued to be of concern. We read on occasions up to four members of staff were required to support this resident. This affected the care other people received. After lunch, despite the increased staffing levels an elderly person was hit by this resident. Necessitating that the person go to hospital for examination.

We noted some people had facial bruising. Staff were not aware of the facial injuries sustained by two of the people we met. The care plan records and incident reports related to these people were not always completed. Some lacked information to show us how these injuries had been sustained, what actions had been taken and whether they had been reported to the appropriate authorities. Staff we spoke with told us they had some concerns regarding the safety for people and staff working at the home. We have reported this under safeguarding.

We reviewed the care plan related to a recent incident when someone had fallen and sustained a head injury. The records regarding this incident was fully completed and showed us on this occasion the provider had acted appropriately. The review of the incident showed us that lessons had been learnt to minimise the risks of similar accidents happening in the future.

We spoke with some people living in the home and their friends and relatives. When we asked people to share their experience of living in the home one person told us, "It`s took a bit but I am getting to used to it, I like it now." A second person told us, "It`s lovely the staff are lovely. I like the food." A third person who was cared for in their bedroom told us, "I am quite happy I am being well looked after." They added they liked their room. We noted their bed had a pressure mattress. This meant the home was taking steps to manage their pressure care.

Relatives we spoke with told us they were happy with the care at the home. One relative said, "They have done well for him. They settled him down as he was agitated. They have a lot of time for him." They told us they mainly saw activities in the afternoon. A second relative told us, "He seems to have settled in and they have been absolutely marvellous. They are very patient with him and I couldn`t think of him being anywhere else." They added "I think these guys do a marvellous job." A third relative told us, "I can always talk to any of the staff if I need to. They do a good job. They'll always tell me if something's happened or he's unwell." However these comments did not always reflect our observations in the home.

We heard that relatives and visitors were welcome at any time and that contact with relatives was good. The provider told us, "We like relatives to feel they're welcome at all times."

Safeguarding people who use services from abuse ✖ Action needed

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

People who use the service were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

We looked to see how the service kept people safe and protected them from abuse or the risk of abuse. We saw that all staff had recently attended specialist training relating to managing challenging behaviour and break away techniques. The provider had issued staff with personal alarms, so that they could summon assistance if they required it.

During our inspection we noted two people had facial bruising. When we spoke with staff and the management team, no one was aware of the injuries or how they had occurred. We referred to the care plan records and incident reports relating to these people. Thorough checking of the care plan records for the first person did not reveal any indication of an incident form and we could not see evidence of entries from staff on the daily observation notes of any mention of the bruising. This showed us that people were not being protected from the risks of abuse and harm posed to them.

In the second person`s records we read an incident report dated 21st June 2014, that stated they had been hit by another resident and had sustained bruising to the right side of their face. Despite there being an on call system in place, staff had not reported the incident to their manager or provider. When we read their daily records they indicated this person had actually been hit twice by a resident on the same day. When we spoke with the staff member who was on duty on that day, they confirmed this person had been hit on two separate occasions, on the same day, by the same resident. This staff member told us they had not received any safeguarding training. They told us they did not know how to report safeguarding incidents. When we spoke with the manager they told us they were not aware that two incidents had taken place. This meant that all three incidents had not been reported to the Local safeguarding Authority. This showed us staff had not responded appropriately when it is suspected that abuse has occurred or is at risk or occurring.

The manager told us their safeguarding training had expired in April 2014 and she told us she had delivered some in house safeguarding training. She acknowledged this training

did not inform staff how to report safeguarding concerns. When asked she told us they did not have a copy of the Local Authority Safeguarding policy available on the premises. This gives guidance and information for staff to follow if they suspect someone is at risk of abuse. The service did have a Whistle Blowing policy in place and this was on display in the home. This policy means staff are protected if they report any poor practises they witness. The service did have contact details on display in the office of services to contact in an emergency including the Local Authority. However it was clear that referrals to the Local Authority had not taken place when incidents of concerns had occurred.

One resident living at the home was supported by one to one to one staffing. This was because of the risks their behaviour posed to others. Despite the increased level of staff support provided, after lunch this resident assaulted a frail elderly person. The victim was very shaken by the assault, and the staff member nearby was visibly distressed. This was because the resident was very quick, and the member of staff had been unable to protect the victim. They also told us the resident was very strong and they were unable to manage them on their own. This meant that people were not being effectively protected from the adverse effects of negative behaviours within the home. We reported the incident to the provider and advised we would be reporting this incident to the Local Safeguarding Authority as part of safeguarding procedures. We saw staff provided care and reassurance for the victim, and medical care was arranged at the request of the victim.

Some staff we spoke with told us they had some concerns regarding the safety for people living in and staff working at the home. We were told of several recent serious incidents. We were told that one incident had been reported to their manager. When we spoke with the manager they told us they were only aware of one recent incident report. When we read this report, we noted it did not relate to the serious incident the staff member had disclosed to us. This incident report we read revealed that a third person living in the home had been recently assaulted by the same resident. Discussions with the manager confirmed this incident had not been reported to the local Authority`s safeguarding team, or the Commission.

One person we spoke with told us that she didn`t always feel safe living in the home. She told us one man pushes her over. She told us she has seen staff being hit. We reported her concerns to the Local Safeguarding Authority.

Upon further discussion the manager told us that the information reported to her regarding the serious incident had not been conveyed in the same manner. This meant that a less serious assessment of the situation had been taken. It became evident that for whatever reason, staff did not always report safeguarding incidents taking place within the home. On the occasions when they did, the gravity and seriousness of the events failed to result in immediate safeguarding action being taken. This highlighted that the trends of recent increasing assaults upon elderly frail people living at the home by the same resident had not been identified. This meant the provider had no effective action plan in place to protect and safeguard people from the risks of abuse posed to them.

Although staff we spoke with told us they had undertaken safeguarding training in the past, and some told us what actions they would take, it was clear that the current systems in place were not working. The manager told she had not undertaken any formal safeguarding training. This showed us people were not being protected from the risks of abuse and harm.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

As part of our inspection we checked how medicines were being managed. This was because we had received information regarding concerns that medication was being administered covertly to people. This means disguising medication in food and drink so that people were being led to believe they were not being given medication.

The nurse told us that covert medication was being given to one person. We read the home had a policy document giving nurses guidance on the use of covert administration of medicines. In this person`s care plan record and medication chart it was clearly recorded that medications could be administered in this way. Discussions had been taken with their GP.

We observed the nurse administering medicines over the lunchtime period. We saw evidence that medicines were appropriately stored, stocked, recorded and administered.

We saw the nurse treat people with respect and dignity at all times. On occasions we observed some people had changeable moods and could be reluctant to take their medication. We saw evidence of people refusing their medication was being sensitively and effectively managed. The nurse told us as well as recording on the medicine administration chart (MAR) she would report any omitted medicines as part of the daily handover. This would enable staff to monitor and observe people more closely.

One person we met had recently moved into the home. Due to their condition they were receiving pain control which was administered on a PRN basis. This means taking prescribed medications as required. The nurse told us the person had the capacity to request pain control. We noted a copy of the home`s policy on the use of PRN medication was stored in the office. The provider may wish to note that a copy of their PRN medication procedure should be kept in the clinic area where medicines were stored and administered. This would ensure nurses had guidance for reference when administering medication.

The nurse explained as part of their pre assessment process a supply of people`s current medication was transferred with them into Lakeland View. On occasions some people had

to change GP`s if moving from another geographical area. The home worked closely with the local GP practice to ensure people were re-registered with a local GP. The home worked closely with their local pharmacy for advice and guidance.

The home administered some medicines known as controlled drugs (CD) we saw they were stored securely and complied with the requirements of the Misuse of Drugs (Safe Custody) regulations 1973.

Overall we found that generally there were safe systems in place to manage and administer medication. This helped to protect the health and wellbeing of people who lived in the home.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at this outcome because we had received concerns regarding the public areas of the home being dirty and worn, a strong smell of urine being present and concerns regarding the health and safety of the home.

During our inspection we conducted a tour of the building and outside patio area to check the safety and suitability of the premises. The layout of the home consisted of two lounge areas, a conservatory area, an internal smoking room, a dining room and a decked outside patio area with perspex panelling overlooking the coastal area. The smaller lounge and conservatory areas were used for sensory activities and were generally used by people who preferred a calmer environment.

On our tour of the premises we saw the provider was in the process of replacing bedroom furniture and beds. A new hall carpet and stair carpets had been fitted. One of the bathrooms had been upgraded to provide wet room facilities. The other bathrooms were currently being re- furbished. During our tour it was evident that managing unpleasant odours and the cleaning of the home was an ongoing process. We observed areas within the home that required attention were being actively managed by the cleaning staff.

During our inspection we did identify several areas for action and reported this to the provider. In nine of the bedrooms, and the conservatory area the window restrictors were either missing or were not secure. In two bedrooms, windows could not be opened at all. This meant there was inadequate ventilation for people. Call bells were in the main in place and working; however we noted that in the shared bedroom there was only one call bell available for people to use. We noted flooring in three of the bedrooms required upgrading or replacing. The outside ramp and handrail was insecure and the step down was not clearly marked. This posed a risk to people.

The outside decking area provided a pleasant alternative choice for people to use. However the perspex panels were not securely fitted and this required some urgent maintenance to ensure its safety. Hot water checks revealed that the temperature of hot

water in two of the bedrooms was too hot.

At lunchtime we noted the dining area of the home appeared to be small and congested for the numbers of people living in the home. We saw some people liked to walk around the dining area, whilst staff were serving hot food from a trolley. The provider may wish to note that reviewing the support they provide for people at meal times may contribute to a calmer and more sociable meal time environment.

We saw maintenance records were in place for electrical testing, the fire alarm and fire equipment. The lift had recently been serviced. Call bells had last been inspected in July 2013. Moving and handling equipment was last inspected in March 2014. The fire and rescue service had returned to the home in February 2014 and had found the home to be compliant with their regulations. The warning notice that had been served had now been removed.

The home had a 5 star food hygiene certificate rating awarded in February 2014. This rating meant the food standards within the home were found to be very good. This showed us the home had systems in place to protect people from the risks associated with food handling.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

We looked at the recruitment and selection procedures in place to ensure people were supported by suitably qualified and experienced staff. In the staff files we saw evidence of pre-employment checks being undertaken. Disclosure and Barring Service (DBS) clearance checks were in place before staff took up a position within the home. In the case of qualified nurses a record of their Nursing and Midwifery Council number was recorded on their file. This was to ensure their registration and qualification was up to date.

Any gaps in peoples employment history was discussed at interview. The provider may like to note in one person`s file, not all the pre-employment checks undertaken were robust. We read one reference check did not relate to the current role and responsibilities of the post. References regarding more recent experience had not been obtained. This information would enable the manager to assess the suitability of the person`s skills and experience and indicate they are of good character. The manager told us it could be difficult to obtain references but told she would ensure a more up to date reference was in place. This would support the provider to uphold robust recruitment processes for the safety and well being of people living in the home.

Newly appointed staff undertook mandatory training and received supervision throughout their probationary period.

Staff we spoke with were positive regarding working at Lakeland View Care Home. Some staff had worked at the home for many years. One staff member told us, "We get plenty of training – dementia, safeguarding, moving and handling, hand hygiene, all of it. There's loads." A second person told us, "I've done all sorts of work here. I really like it."

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people`s needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked to see how the home was being staffed. This was because we had received some concerns regarding the frequent use of agency staff within the home. We did this to make sure there were enough staff on duty at all times to support people living in the home.

The manager told us they had a number of vacancies but had made some recent appointments. There remained one vacancy for a qualified nurse and a carer. We were told they tried to use the same agency when covering shortfalls in their staffing. The manager told us they requested staff who had worked at the home before. This was to try to provide a consistent service for people who lived at Lakeland View. The manager told us she felt well supported by the provider, who would provide additional staff cover should the service require it.

During our inspection we noted that the deployment of staff was not always managed effectively. In the morning we observed there were occasions when only one staff member was available to meet the needs of up to15 people. We saw some people were left unoccupied for long periods of time. We saw staff were pleasant and kind but did not have the time to get involved with people. Where they tried to engage this was limited as they were interrupted by the needs of other people.

One resident required one to one staffing. This was because of the risks their behaviour posed to others. Although the manager told us they had applied for additional funding to support this person, this had been declined. When we read this resident`s care plan records, we noted that a recent review referred to this resident requiring up to four staff to support them. This meant the staff support was provided from the existing staff team. The provider had no actions in place to improve this situation. This was to the detriment of the care delivery to the other residents. Despite the increased staffing levels provided, during the inspection this resident hit an elderly frail person.

A member of staff told us they felt scared if they were not with another member of staff, because this resident`s behaviour was so unpredictable. This affected the care and

welfare of the people living at Lakeland View.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people received. The provider did not always act on the information they received.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Although the management team had a range of systems in place to monitor the quality of the service, we did not see these were effective. We identified shortfalls with the management and reporting of safeguarding incidents within the home. Records of incidents were not always reported to the appropriate people or accurately recorded. This was because staff had not responded appropriately to allegations of abuse. This meant the risks posed to people were not being effectively managed.

We noted from our observations in the home that some people has suffered an injury, and staff were not always of aware of them. Records in care plans did not outline what action had been taken to minimise the risks posed to people.

The manager told us she had researched, devised and delivered her own safeguarding training for the staff team. However we noted the training being delivered did not inform staff how to report any safeguarding concerns. Our discussions with the manager acknowledged this omission. The staff training matrix indicated staff had completed a range of training courses. We noted there was a gap in providing person centred care training. However the provider told us they were part of a national Dementia Care Audit pilot study. They told us participation in this had been very beneficial and they had identified some Dementia training as a result. The provider told us they felt this would meet the gap in person centred care training.

We saw the deployment of the staff across the home was not always managed effectively. During the morning we observed there were occasions when only one staff member was available to meet the needs of a large group of people. We saw people were left unoccupied for long periods of time. One resident required one to one staffing. This was because of the risks their behaviour posed to others. This affected the care other people received. The provider had no actions in place to improve this situation.

Although there was a programme of refurbishment in place, there was no oversight regarding the concerns we had identified regarding the areas requiring essential maintenance work for the health and safety of everyone living, working and visiting the home.

There was a new manager in post and she told us she felt well supported by the provider who worked in the home on a regular basis. She had recently submitted a Registered Managers application to the Commission. The management team met on a regular basis to undertake clinical governance across the home. We looked at a copy of the previous minutes and read that medication, care plan and activity audits had been undertaken.

We were told that relatives meetings are held every alternate month. Although the provider recognised that supporting people to give feedback is a major challenge for them, they told us they worked in partnership with local advocacy services.

Notification of death of a person who uses services ✓ Met this standard

Adult social care and independent healthcare services must tell us when somebody dies in their care. NHS services must tell us when somebody dies because they have not been given the right care

Our judgement

The provider was meeting this standard.

The provider had notified the Commission without delay, of the death of a service user.

Reasons for our judgement

It is a requirement of the Care Quality Commission (Registration) Regulations 2009, that the provider must notify the Commission without delay of the death of a service user who was resident at the home.

We had reviewed our systems and they showed the provider had notified the Commission of previous deaths. The manager showed us the system they maintained within the home of notifications they submitted to the Commission. The manager told us she was aware she should submit notifications regarding deaths and serious injuries. However she told us she was not aware of the other instances she should submit notifications to the Commission and the appropriate authorities. We have reported this under notification of other incidents.

Notification of other incidents ✖ Action needed

The service must tell us about important events that affect people's wellbeing, health and safety

Our judgement

The provider was not meeting this standard.

The provider had not notified the Commission without delay, of the serious injury to a service user. The provider had also not notified the Commission of the abuse or allegations of abuse in relation to service users.

We have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

It is a requirement of the Care Quality Commission (Registration) Regulations 2009, that the provider must notify the Commission without delay of any serious injury to a service user or any abuse or allegation of abuse in relation to a service user. This is to enable us to monitor services effectively and carry out our regulatory responsibilities.

During the inspection we had been informed that concerns had been raised regarding the care and well- being of some of the residents. Several staff members told us of incidents when some residents had been hit by another resident living in the home, as well as staff members.

On the morning of our visit we saw two people had facial bruising. When we spoke with staff they told us they were unaware of the bruising. Thorough checking in the first person`s care plans did not reveal any indication of an incident form and we could not see evidence of entries from staff on the daily observation notes of any mention of this bruising.

In the second person`s care plan we read an incident report indicating this person had been hit by a resident at the weekend. Despite their being an on call system in place, staff had not reported the incident to their manager or provider. On the following Monday, the management team told us they were unaware of the incident. When we read the daily records relating to the day of the incident, we saw that this second person had actually been assaulted twice at different times of the day by the same resident. There was no incident report regarding the second incident.

We reviewed the incident reports and care records regarding the resident who was assaulting some residents within the home. Despite the concerns raised by staff we noted there was only one incident report recorded in June 2014. When we read the details of this incident, this referred to a third person living at the home. The report indicated they had been assaulted by the same resident. When we spoke with the manager she told us she was not aware she had to report such incidents and therefore had not notified the

Commission or the Local safeguarding Authority.

This showed us the provider had not notified the Commission without delay of any serious injury to a service user or any abuse or allegation of abuse in relation to a service user.

Our systems showed that the Commission had not been notified of these incidents of abuse or the injuries sustained by people.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider did not taken proper steps to ensure that people living at the home were protected against the risks of receiving care or treatment that was inappropriate or unsafe. The process of planning and delivering care did not always take account of how best to meet people`s individual needs, or ensure their welfare and safety. Plans and procedures were not in place for dealing with changes in people`s care and how best to support and protect people.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The provider must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises.

This section is primarily information for the provider

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: In order to safeguard the health and safety and welfare of service users, the provider must take appropriate steps to ensure that at all times there are sufficient numbers of suitably qualified, skilled and experienced staff on duty.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The registered person must protect service users and others who may be at risk, against the risks the risks of inappropriate or unsafe care and treatment. There wasn`t an effective system in place to monitor and analyse the behavioural incidents within the home. Suitable arrangements were not in place to respond appropriately to allegations of abuse.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 CQC (Registration) Regulations 2009** **Notification of other incidents**
	How the regulation was not being met:

This section is primarily information for the provider

Diagnostic and screening procedures Treatment of disease, disorder or injury	The registered person must notify the Commission without delay of the incidents specified in paragraph (2) which occur whilst services are being provided. Such as an injury to a service user and any abuse or allegation of abuse in relation to a service user.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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