North West Care Limited

Lakeland View Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

We inspected Lakeland View Care Centre in the 21st, 23rd and 24th November 2014. This was an unannounced inspection. This meant the staff and the provider did not know we would be inspecting the home.

The last inspection was in June and July 2014. That was a responsive inspection undertaken because we had received information of concern regarding this service. At that inspection we identified breaches in the regulations related to the care and welfare of people, safeguarding, the safety and suitability of the premises, the staffing levels, assessing and monitoring the quality of the service and the lack of notifying the Commission regarding safeguarding and serious injury notifications. At this inspection we undertook checks to see what improvements had been made.

Lakeland View Care Centre can accommodate up to 33 people, who require nursing or personal care, diagnostic and screening procedures and the treatment of disease, disorder or injury. People who live in Lakeland View are older people and may have conditions such as dementia, mental health needs, a physical disability or a sensory impairment.

Summary of findings

At the time of our inspection the home was fully occupied. 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 an outside decking area. Accommodation is provided on two floors. Most rooms are single, with shared bathroom facilities.

The home did not have a registered manger in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. They share the legal responsibility for meeting the requirements of the law; as does the provider.

We spent time in the communal areas of the home, including the lounge and dining areas. This helped us to observe the daily routines and gain an insight into how people`s care and support was managed.

We found the registered provider had breached Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found people were not always supported to make a choice at mealtimes. Some people were not effectively supported at mealtimes. You can see what action we told the provider to take at the back of the report.

Following the last inspection in June and July 2014 the provider had sent us an action plan telling us what improvements they intended to make. During this inspection we found the provider had made steady improvements with their safeguarding systems. The provider and staff team had worked collaboratively with a range of external agencies to support their safeguarding systems. Relatives we spoke with told us they felt their family member was safe living at the home. We were told that staff were always helpful when they visited and the home felt welcoming.

We also found the provider had made improvements in other areas including their staffing levels, and with their infection control measures. There was a rage of stimulating activities provided for people to participate in. The provider had recently recruited a new manager who was fully aware of the shortfalls within the service. In the care plan records we looked at we saw evidence to show the provider was responding to changes in people`s condition by seeking advice from a range of healthcare professionals. This was also supported by our observations during the inspection when health care professionals visited people in the home when requested by the qualified nurse on duty.

The provider had policies and guidance in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DoLs). The MCA and DoLs provide legal safeguards for people who may be unable to make decisions about their care. We spoke with the provider who demonstrated an awareness of the code of practice. However we noted further work was required to ensure the measures they had in place reflected the needs of the client group who lived at the home. Although the provider had a policy in place regarding pain management this information was not evident in the treatment room where medicines were administered from. This was of particular concern because some of the people living in the home were unable to express when they were experiencing pain.

The provider had undertaken extensive work in their clinic area. The area had been completely refurbished, with new wipe down surfaces and lighting. The provider had taken advice and guidance with regard to their infection control measures. They had purchased a new medication storage facility located in the clinic area. Medication was safely stored and clearly labelled to assist staff with the safe administration and management of medicines. Other improvements undertaken included the provision of new hand washing and drying facilities in people`s bedrooms. We found these improvements helped to protect people with the additional prevention and control of infection measures.

Although we found the provider had made progress with improvements in a number of areas, we identified some areas that required further work. This would ensure people benefitted from living in a well-managed home.

Summary of findings

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.

Since the last inspection the provider had undertaken changes to make improvements to safeguard people from risks of harm and abuse. However there remained a high level of safeguarding incidents taking place within this home.

The safety of the environment was not always actively managed to ensure it was safe for the people who lived in the home.

The provider`s policy regarding pain management was not available in the treatment room where medicines were administered from.

The service had a range of safeguarding systems in place to protect people from the risks of harm and abuse. The provider was reporting safeguarding incidents to the appropriate authorities.

We found the staffing levels had improved, and there were sufficient staff available to meet the assessed needs of people. The care and risks for people was planned for and co-ordinated on a daily basis by the team leader.

Generally we found that medicines were safely managed.

The provider had undertaken extensive work in their clinic area. The area had been completely refurbished; with new wipe down surfaces and lighting The provider had improved their prevention of infection control measures.

Is the service effective?

Requires Improvement

The service was not always effective

The support provided for people to eat and drink was not always adequate. We found some staff did not talk with or provide encouragement with people when they supported them to eat their meal. Some people were not supported to make choices at mealtimes.

We also found that some areas of the home required urgent maintenance action. We found the bathroom on the top floor was in a poor state of repair. The lift was readily accessible to the people who lived at the home. For those who had dementia type conditions this posed a risk. The measures to manage the risks posed to people regarding the outside decking area were not robust. Urgent electrical work had not been responded to in a timely way.

Some senior staff members were not confident when applying the principles of the Mental Capacity Act to the care they provided.

Is the service caring?

Requires Improvement

The service was not always caring.

Summary of findings

There was no care planning system in place to support people with their wishes when nearing the end of their life.

People who lived at the home were seen to be supported by caring staff.

People and their relatives told us staff were caring and treated people with respect and dignity.

Staff we spoke with showed us they had a good understanding of people`s needs.

Is the service responsive?

Good

The services provided were responsive to meeting the needs of people.

The provider was responding to changes in people`s condition by seeking advice and support from a range of healthcare professionals

People were supported to participate in a range of group and person centred activities.

People`s care plan records were kept under review.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality monitoring systems within the home had failed to identify the inconsistencies in the care people received.

Mental capacity assessments could be more robust. There was no assessment in place to asses people`s ability to express pain. Therefore people may not receive pain control medication as and when required.

End of Life care had not been developed into their care planning system to support people and their relatives with their end of life wishes.

Some aspects of the environment lacked oversight by the provider. The environment was not conducive to supporting the needs of older people with dementia type conditions. Some areas of the home required urgent maintenance action.

Lakeland View Care Centre

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 checked 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.

This inspection took place on 21st, 23rd and 24th November 2014 and was unannounced. This meant the staff and the provider did not know we would be inspecting the home.

The inspection team consisted of a lead inspector, two additional inspectors, a specialist adviser and an expert by experience. The specialist adviser has a professional background in providing care for people who use this type of service. The expert by experience has personal experience of caring for someone who has dementia type conditions.

Before the inspection we did not ask the provider to complete a Provider Information Return (PIR).

This was because the provider had an action plan in place and was undertaking a range of service improvements to address the shortfalls identified at the last inspection in June 2014. The PIR form asks the provider to give some key information about the service, what it does well and the improvements they plan to make.

We contacted Lancashire County Council Commissioning Team. We did this in order to ask their opinion of the service. There were no concerns reported to us regarding this service. The local safeguarding team were currently undertaking safeguarding investigations into allegations reported to them by the provider. The provider was working collaboratively with the safeguarding team as part of their investigations.

We reviewed information we held about the home, such as statutory notifications, safeguarding information and any comments and concerns. This guided us to what areas we would focus on as part of our inspection. We looked at previous inspection reports.

During the inspection we used a method called Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. This involved observing staff interactions with the people in their care.

We spoke with three people who lived at the home, three relatives, a visiting minister, the provider, the new manager and four members of the staff team. We also looked at a range of records which included six people`s care plan records and risk assessments.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found people who used 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.

At this inspection we found the provider had undertaken a range of measures to improve the safety of the services they were providing for people. The provider had developed working partnerships with the local safeguarding authority and other professionals. This meant the provider could access advice and support should they require it regarding any safeguarding matters that may arise.

Since the last inspection there had been a significant improvement in the reporting of safeguarding incidents to external agencies. This meant that there was an external oversight regarding the frequency and nature of safeguarding incidents taking place within the home. This enabled the safeguarding team to investigate allegations of abuse. From a review of the current records and systems in place, we saw the provider had submitted reports appropriately. However there remained a high level of safeguarding incidents taking place within this home. The provider told us they specialised in caring for people who presented with behaviours that challenged. He told us they reported all incidents to the appropriate authorities and involved people`s relatives. The provider worked closely with the staff team, relatives and outside agencies. This helped to protect people.

Other improvements made by the provider were a lead qualified nurse was now assigned to be the safeguarding lead for the day. This meant it was their responsibility to manage any incidents, complete reports and ensure relevant people were informed. This clarity within the role meant there was less risk of any confusion between staff taking place. We read that all incidents reports were emailed directly to the provider for their oversight. This showed us there was an additional measure in place to ensure that any incidents had the attention of the provider should any other urgent action be required. As part of their monthly clinical governance meetings the provider had devised a form to assist them with their monitoring of frequency and severity of incidents. This form had been newly implemented and therefore we were unable to monitor how effective it was.

Staff had undertaken safeguarding training that had been recommended by the local authority safeguarding team. Staff we spoke with were able to explain what actions they would take if they suspected someone was at risk of abuse or harm. In our discussions staff told us they were aware of the home`s whistleblowing (reporting bad practice) policy. This means that staff were protected should they report any concerns regarding poor practice in the work place. Staff we spoke with were very clear about their responsibilities to report any concerns they may have regarding keeping people safe. It was evident from our discussions that the provider supported staff to actively raise concerns and challenge any poor practises should they observe in the workplace.

We observed the care and support provided for people. On occasions when there was potential for conflict between some people who lived in the home, we observed staff were present to provide support and assistance. We observed staff use distraction techniques and on one occasion re- directed one person into another area of the home. This worked to good effect. During our inspection we did not witness any escalation of incidents. The ground floor layout of the home allowed for a circulatory route. This enabled people to freely walk around their home and spend time in areas of their choosing.

At the last inspection we found there were not always enough qualified, skilled and experienced staff to meet people`s needs. At this inspection we found that the care and risks for people was planned for and co-ordinated on a daily basis by the team leader. It was their responsibility to ensure staff were allocated to support people with their needs. This meant there was sufficient staff support available at all times to monitor and provide assistance when required. We saw during our inspection that staff were effectively deployed across the home to support people. This was an improvement from the previous inspection. Staff were also given detailed handover notes, giving them information regarding the level of support individual people required.

One person we spoke with told us, “There is always plenty of staff in the home and they will do anything for you.”

We spoke with several relatives. Comments we received regarding people`s care was positive.

Requires Improvement

Is the service safe?

“There are always plenty of staff on duty whenever we come into the home, we visit the home every day and at different times of the day and night and the staff always make time to speak with us.” They also told us they felt their relative was safe.

Staff told us they felt the staffing levels were adequate. One staff member told us they felt the staffing levels had improved since the last inspection. The new manager told us there was now an additional staff member on duty in the early morning, as some people preferred to get up early. The new manager told us the provider always supported them to deploy additional staffing should people require it. This showed us the provider was taking steps to have robust systems in place to safeguard people who lived at the home.

We looked at the recruitment and selection procedures the provider had in place to ensure people were supported by suitably qualified and experienced staff. We looked at four staff records. We saw evidence of pre-employment checks being undertaken. There was a full employment history, and any gaps were explained. Interview notes were recorded and maintained in the files. There was evidence of reference and Disclosure and Barring Service (DBS) checks undertaken.

Following their recruitment, staff we spoke with told us they were supported through an induction process. The provider had recently recruited a new manager and they told us they felt they were supported through a period of induction to assist them to take on the responsibilities their new role intended.

As part of our inspection we checked how medicines were being managed. We observed the nurse on duty administer medicines over the lunchtime period. We found medicines were safely stored and were clearly labelled in a new medicines storage cabinet. This facility helped staff with the safe administration and management of medicines. The home worked with the local pharmacy to ensure they had adequate stocks in place. There was a system in place for returning any surplus stocks of medicines. We observed the nurse safely administer medicines over the lunchtime period. We did note that handwritten entries on the medication administration sheets were not countersigned to ensure their accuracy nor were they dated. We fed this back to the provider to ensure they could take appropriate action.

There was one person who received medicines covertly. Covert administration of medicines is used in instances when a person may refuse their medications but may not have the capacity to understand the consequences of their refusal. There should be a legal process in place to reflect that such decisions are made by a multidisciplinary team, and if possible family members. In this person`s care plan records we saw that a multi-disciplinary meeting had taken place to discuss how to support this person to take their medicines safely. This meant the provider was acting lawfully and in the best interests of the individual concerned.

When we observed the lunchtime administration of medicines, the providers policy regarding the use of pain management was not available in the treatment room. This meant information was not to hand should qualified nurses require it for guidance. This was of a particular concern because some of the people who lived at the home may be unable to express when they were experiencing pain. We fed this back to the provider for their appropriate action.

Since the last inspection the provider had met with various professionals regarding aspects of their service provision including infection control. The provider had undertaken extensive work in their clinic area. The area had been completely refurbished, with new wipe down surfaces and lighting.

Our checks in some of the toilet and bathroom areas showed us they were clean and tidy. There was evidence of protective clothing available for staff to use when providing assistance with personal care. There was evidence of hourly checks taking place in the toilet areas. This helped to monitor the standards within the home and ensure it was kept clean for people to use. The provider had also installed paper towel dispensers and new waste bins in people`s bedrooms. This assisted staff with their infection prevention and control measures.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found people and other visitors were not protected against the risks of unsafe or unsuitable premises. We noted the provider had undertaken areas of work to make improvements with the environment.

The provider had now installed new window restrictors. However we found this was not consistently applied to all of the windows in the home. In one upstairs room we found one window restrictor was incorrectly fitted. In a second room there was a missing window restrictor. This meant the window openings still posed potential risks to people because the safety measures in place were not robust. The provider told us they would take immediate action to remedy the two windows.

There was some concern discussed at the inspection whether the type of window restrictor was suitable for the client group who lived at Lakeland View Care Centre. The provider told us they would contact the Health and Safety Executive for their advice and guidance.

Since the last inspection there had been a serious incident when one of the people who lived at the home had managed to climb over the garden fence that surrounded the decking area and leave the home. Following this incident the provider had undertaken an investigation and restricted access to this area to minimise a repeat of this happening again. The matter had also been appropriately reported to the local authority safeguarding team for their investigation. However despite the measures the provider had in place we found they were not robust. Although the door to the decking area was now secured, with an alarm fitted, should someone have any level of determination it could easily be forced open. Once on the decking area there remained several items of furniture that could be used to help people to climb over the garden fence. We discussed this with the provider that more robust actions were required. The provider told us they were awaiting a quoted from a contractor to fit an extra lock to the door. As part of their actions to minimise the potential risks posed to people staff are required to supervise people when using the decked area.

During our inspection we could smell cigarette smoke that came from the smoking area on the ground floor. At times it was unpleasant and we noted there was a lack of ventilation in the smoking room. For anyone walking by, there was a risk of passive smoking and the presence of an unpleasant odour. We discussed this with the provider, who assured us there was a new extractor fan in place. He advised that sometimes when people used the smoke room they would turn the fan off. The provider told us they would implement daily checks to ensure staff monitored the use of the fan when people used the smoke room. They assured us this would alleviate the strong smells of cigarette smoke within that area of the home.

We found the lift was readily accessible to the people who lived at the home. For those who had dementia type conditions this posed a risk. This was because some people may easily become disorientated and may not have the capacity to use the lift safely. The provider told us they planned to replace the lift. However they had considered that with all the work they had recently undertaken within the home, they had decided to postpone having the replacement lift fitted. They had prepared a business continuity plan to support people and the staff during the process of the building work required to facilitate this. In the meantime we asked the provider to undertake a risk assessment to ensure they were managing the risks posed to people.

We also found that some areas of the home required maintenance action. We found the bathroom on the top floor was in a poor state of repair and required updating. The previous week a contractor had undertaken testing of the electrics in the home. We found a plug socket with a failed sticker on it, but saw this was still being used. It had an electrical extension plugged into it. We fed this back to the provider, As there were contractors on site they took immediate action to ensure the plug socket was made safe.

We found the environment was not conducive to the needs of older people with dementia type conditions. There was a general lack of signage and use of colour to assist people find their way around their home and to support their independence. Current research indicates that the use of colour and signage can be helpful to people with dementia type conditions. We fed this back to the provider to assist them with their service improvements.

We found an additional call bell had been fitted in the double bed room. This meant the two people sharing that bedroom had access to a call bell should they require it. There was new flooring fitted in the bedrooms and along the top corridor**.** Wooden supports had now been fitted to

Is the service effective?

the outside decking to help to strengthen it. This showed us the provider had taken a range of measures to improve the environment for the people who lived at Lakeland View Care Centre.

We found the support provided for people at mealtimes was not always good. We saw some people who were very dependent were not sufficiently encouraged by some staff to eat their meal. We observed some staff did not use any communication with those people who were unable to speak and in one instance we observed a member of staff stand over the person they were supporting. This did not foster a social activity or demonstrate respect for the person concerned. We saw some people were not offered choices at mealtimes.

Over the three days we inspected it was evident that the quality of support provided varied. Indeed we saw some people received good levels of support dependent upon their needs and the location where they sat to eat their meal. In one area of the home we saw that mealtime was a more sociable experience. That staff member provided encouragement for people to eat at their pace, and fostered a social experience for those being supported.

We spoke with the cook, who told us they prepared and cooked meals on the premises. There were two hot meal options available for people. The cook told us they were aware of how to fortify foods. The cook told us staff had recently received some training regarding nutritional risk assessments. The cook was aware of people`s likes and preferences, and told us they were aware of people`s allergies. However this information relied upon the memory of the cook as there were no records stored in the kitchen for advice and guidance. We discussed with the cook that maintaining their own records would ensure they were kept up to date regarding any risks posed to people.

We found the lack of support and lack of choice for people at mealtimes was a breach of Regulation 14 of the Health and Social Care Act 208 (Regulated Activities) Regulations 2010.

Staff completed food and fluid diaries. There was evidence of regular weight monitoring taking place for those people assessed as being at risk of inadequate food and fluid intake. We read in people`s care plans there were regular reviews, and referrals were made to the dietician and GP if they had concerns. Our discussion with the provider showed us they had a good understanding of people`s dietary needs and what action to take should they have any concerns.

Care staff were given daily handover information identifying those people who had been assessed as being at risk. Guidance included the frequency of weight monitoring. We noted for one individual this has been increased to twice weekly, to ensure staff were closely monitoring for any changes. This showed us staff had information they required to ensure people were supported appropriately.

One relative we spoke with told us, “She is eating better; she said she liked pears and they went out and bought her some.” However this was not the experience for other people. One person we spoke with told us that sometimes they had to wait a long time for their meal and sometimes it was cold.

There was a staff training plan in place to support staff to undertake a range of training over a twelve month period. Recent training courses staff attended included safeguarding, infection control, first aid and moving and handling. Other courses some staff had attended were food hygiene, health and safety, fire safety, caring for people with dementia, supporting people with mental health and learning disabilities, and compassion and dignity in care. Three staff had undertaken nutritional assessment training.

Staff we spoke with told us they received regular training and supervision. One staff member commented, “We have had a lot of training including online dementia training”. A second staff member told us they had worked at the home for several years and had been promoted to a more senior role. A third staff member told us they had been trained to keep the people who used the service safe and how to use risk assessments. This showed us the provider supported staff in some areas of their personal development.

However it was evident during our inspection that some staff lacked in confidence and skills to respond to people`s needs effectively. On one occasion we observed staff perform a moving and handling manoeuvre unsafely. On a second occasion we observed staff transfer a person from her wheelchair to a chair using a hoist. Because staff did not explain to her what was happening she looked frightened. We discussed our findings with the provider. They acknowledged our concerns and told us a moving

Requires Improvement

Is the service effective?

and handling course was planned to take place later that week. We did observe that the planned training took place; with some of the less experienced staff attending that training. This meant the problems we had identified would be addressed by the training provided, but this was not done proactively.

We spoke with visitors and relatives. One relative told us, "My mother's needs are met by the staff and they know what they are doing to help with her day to day living." A second relative shared the same experience and added "the staff are meeting his mother's needs." One of the people who lived at the home commented, "My needs are met by the lovely girls in the home." This showed us people were supported by staff who understood their needs.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DoLS) provide legal safeguards for people who may be unable to make decisions about their care. The provider had recently attended training provided by the local authority. Our discussions confirmed they were aware of their responsibilities to apply to the local authority to ensure any care practices were lawful and they were acting in the best interests of the individual concerned. We saw documentary evidence in some of the care plans that indicated the provider had made DoLS applications to the local authority. There were assessments in place to establish any potential restrictive care practices in relation to the Deprivation of Liberty Safeguards (DoLS).

When we spoke with staff, one senior staff member gave us conflicting information regarding their attendance on a recent Mental Capacity Act training course. A second senior staff member was unable to tell us what action they would take should a vulnerable person want to leave the building. This showed us some senior staff members were not confident when applying the principles of the Mental Capacity Act to the care they provided.

Requires Improvement

Is the service caring?

Our findings

We observed some good practice when staff supported people sensitively and with respect. We saw staff demonstrated caring relationships with people they supported. Observation of the staff during the inspection demonstrated they knew the likes and dislikes of the people they cared for.

Comments we received from relatives and those people who were able to tell us, were extremely positive regarding the staff at the home. One relative told us, "She is settling in wonderfully, she loves it. We very much feel involved, they inform us of everything. I could approach staff if we had any worries. We honestly feel it is the best thing we have done." A second relative added, "the staff are very compassionate in their care of my mum. We were involved in the care planning for mum and also in any changes that have taken place". A third relative told us, "We had to go away on holiday when my mother came into the home and the staff treated her with compassion during this time and settled her in".

A tour of the premises indicated people`s bedrooms were decorated with people`s personal effects. Their rooms looked homely and comfortable. This showed us staff supported people to express their individuality in their personal space in the home.

We looked to see how the provider supported people and their relatives to make plans to reflect people`s wishes towards the end of their life, known as end of life care. We were aware some people who lived at the home were elderly and frail and some people had serious underlying health care needs.

When we discussed this area of care with staff and the provider we found staff worked with the local health care professionals to manage people`s care needs towards their end of life. There was access to specialist palliative care and staff at the home had a good relationship with the local hospice. Where it was identified, if people required specialist equipment for end of life care, the equipment was found to be in place. Arrangements were in place to ensure medicines were prescribed and available for people including pain relief.

However we found at this inspection the provider did not have any systems in place to support end of life care planning. This meant that although there was a commitment to deliver good end of life care, the provider had not identified what support people required to be in place. This meant that care plans did not indicate what people`s wishes were and how staff should provide this support.

When we spoke with one senior staff member they told us they had undertaken some e- learning training but did not find it applicable to their residents. When we asked what was their understanding of the end of life care pathway they told us, "it depends on the individual but maybe the last two weeks." When we looked at the staff training matrix it indicated staff training was planned for November 2014, but this has not been achieved by the date of our inspection. This showed us staff were not supported with the skills and knowledge to undertake this specialised area of care.

The home worked with advocacy services so that people who lived at the home could receive impartial support. The provider recognised that as part of their safeguarding measures, they wanted to strengthen their links with advocacy services. They had taken recent advice from the local authority in relation to this. This showed us the provider was involving other professionals to support people`s advocacy at Lakeland View Care Centre. We found the staff at the home had worked to improve the ways they supported relatives to be involved in the care and support of their loved ones. We saw evidence of a best interest meeting taking place.

We recommend that the service explores the relevant guidance on how to implement best practice with the end of life care they provide for people and their relatives.

Good

Is the service responsive?

Our findings

At the last inspection we found that people did not experience care, treatment and support that met their needs and protected their rights. This was because plans and procedures were not in place for dealing with changes in peoples` care and how best to support and protect people. We also found that the planning and delivery of care did not always take account of how best to meet people`s individual needs.

Since that inspection the provider had devised new guidance for staff to follow, in the event of anyone living at the home suffering from deterioration in their mental well-being. This meant that the provider was able to support the staff team to respond more effectively to changes in people`s conditions. The provider had also improved their systems for reporting incidents of concern. All incident forms and notifications now came to him for his oversight. Records and systems we reviewed at this inspection showed us that their systems were more robust and reports were made in a timely manner to the appropriate agencies. This meant any changes affecting people would be acted on and responded to quickly.

During this inspection several people experienced changes in the health and well-being. We observed staff arrange for medical professionals to attend the home for advice and support. This showed us staff were responding to changes in people`s needs.

We looked at six care plan records and risk assessments. Information in the care plans included a pre assessment of people`s needs. There was an extensive range of medical and mental health care need assessments as well as a range of risk assessments. We found care plans were regularly updated, reviewed and monitored. Information in the care plans assisted staff with the information they required to support people with their needs. In addition staff attended a daily handover meeting and were given a prompt sheet indicating the type and level of support people required. This showed us care plan records contained a range of information to enable staff to support people effectively.

The pre assessment was undertaken by the provider, although we were told the new manager would undertake these in the future. We discussed the importance of a robust pre assessment process given the complexity and vulnerability of the client group they supported. The provider told us since the last inspection he was more mindful of this requirement. He told us that he had refused some people a place at the home because of their limitations to meet their complex needs.

There were two activity coordinator's on duty who supported a range of group and person centred activities. The lead coordinator had developed individual life histories for people, and had recorded this information in individual files with people`s photographs. Information recorded was produced to a high standard and was very respectful regarding peoples` personal backgrounds. This information helped staff to provide suitable activities for people and to develop caring relationships. We found activities provided were imaginative and stimulating for people. One person was supported to attend a local group for support with their condition. One relative told us, “We come in every day and it doesn`t matter what time we come in they are doing something different.”

During our inspection there was a local minister visiting to provide spiritual support for people who shared these beliefs. The minister visited the home regularly and told us they always found staff very helpful. This showed us people`s faith and beliefs were supported by the local links the home maintained.

Relatives we spoke with gave us positive feedback. One relative told us, “The care is focused on mum and her care needs are reviewed every month. When mum was more able, she liked the activities. Adjustments have been made for mum’s condition by getting her specialised equipment.” A second relative told us, “The activity co-ordinator helps service users to maintain their hobbies and interests. By focusing on service users every day when they can choose what films/music the resident’s listen to that day.” One person who lived at the home commented, “they come in the night very quickly if I need them.”

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in June 2014 we found the provider did not have an effective system in place to regularly assess and monitor the quality of the service that people received. We found the provider did not submit notifications to the Commission without delay of any serious injury or allegations of abuse in relation to people living in the home. There wasn`t an effective system in place to monitor and analyse incidents when people presented with behaviours that challenged.

At this inspection we found the provider had taken on board our concerns and had undertaken significant areas of work to make improvements. This included more robust safeguarding systems in place. Closer working relationships were forged with local professionals for guidance and support. The provider was now submitting notifications informing the Commission of incidents in relation to the people who lived at the home.

We found the provider worked closely with the staff to support improvements in the services they provided. There were daily handover meetings, Staff were in daily communication with the provider, who in turn had an open door policy. This meant staff could discuss any concerns. Staff we spoke with confirmed they felt supported by the provider.

What worked well in the home was the person centred activities organised and delivered by the activity coordinators. This meant people benefitted from a range of group and person centred activities taking place.

The provider had appointed a new manager who was being supported through a period of induction. The new manager told us they had accepted the post, fully aware of the difficulties the home was experiencing. In our discussions they told us their priorities for taking the service and how they planned to work with the provider and staff team to achieve this. We found the delivery of care was not always consistent for the benefit of the people who lived in Lakeland View Care Centre. The new manager told us it was their priority to review the skill mix of staff. She advised she would ensure this was reflected in the staff rotas. This assured us that steps would be taken to address the inconsistencies in the delivery of care we observed. It was the intention of the new manager to submit a registered manager's application to the Commission.

The provider was working with a range of professionals to make improvements. The provider had invested in the refurbishment of a new clinical area with a new medicine storage cabinet. The provider had invested in a range of infection control measures to improve the services they provide in the home.

There were 'resident's and relative' meetings taking place in the home where any concerns could be discussed. The provider had met with relatives following the previous inspection to discuss the concerns highlighted. This demonstrated how the provider cultivated an open and transparent culture in the home to support positive relationships with relatives. Relatives we spoke with told us they valued the presence of the provider within the home.

We read several comments, compliments and a complaint the provider had received following that inspection. We saw the records regarding these issues, were kept on file. It was clear that the concerns raised were openly discussed, acknowledged and investigated by the provider. We could see he had responded by learning from feedback from relatives and had subsequently made changes. One of the main changes made was to fully inform and involve relatives following any safeguarding incident within the home. This showed us the provider had a taken responsibility for the previous shortfalls in their service and was involving people in making improvements. Relatives we met gave us positive feedback regarding the service provided. One relative told us, "The home is very organised and well led by the owners". Our observations showed us the provider was very hands on and visible to staff and relatives as well as the people living in the home. This showed us the provider and staff worked well together as team.

The provider had devised a monitoring form to analyse the levels, frequency and type of incidents and accidents occurring in the home. This helped to improve the oversight that was found to be lacking at the last inspection. Although it is acknowledged the home provided specialist provision for older people who presented behaviours that challenged the service, there remained a high incidence of safeguarding incidents within this home. We discussed this with the provider as part of our feedback. He told us they were aware of the frequency

Requires Improvement

Is the service well-led?

of incidents and advised us their pre assessment process had become more focussed when considering the suitability of any new referrals being requested to the home.

Following the last inspection we had asked the provider to review the needs of the client group they supported. This was because we considered their main priority of providing specialist care for their client group was unclear. This could impact upon people being inappropriately referred to the home for their care and support. The provider told us they intended to undertake this review but had not completed this task due to the areas of work they were currently undertaking to make improvements. We asked them to include this review as part of their action plan following this inspection.

Although it was clear the provider had undertaken significant areas of work to improve the service they were delivering, there remained some aspects of the service that still required improving. However in our discussions with the provider, we found they had taken immediate action to address some of the concerns we identified. This related to issues with the environment, the provision of moving and handling training and improving their environmental risk assessments.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person did not ensure people were supported to make a choice at mealtimes. Some people were not effectively supported at mealtimes. Regulation 14 (1) (a) (c)