Review of compliance

North West Care Limited Lakeland View Care Centre	
Region:	North West
Location address:	220-224 Heysham Road Heysham Morecambe Lancashire LA3 1NL
Type of service:	Care home service with nursing
Date of Publication:	July 2012
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 and is registered for 33 people. Accommodation is provided on two floors. Most rooms are single, with shared bathroom facilities.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Lakeland View Care Centre was not meeting one or more essential standards. Action is needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider and carried out a visit on 4 July 2012.

What people told us

We spoke with some residents and three visitors to the home. Many of the residents were unable to give direct feedback because of their conditions. Those who did were all positive about the staff and the care they received. One visitor told us that although the place was "shabby" the staff were very kind and looked after people well. She said, "It's better than a smart place where nobody cares". We also spent time observing care and watching while a meal was served.

What we found about the standards we reviewed and how well Lakeland View Care Centre was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

The provider was meeting this standard.. People's privacy, dignity and independence were respected.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider was meeting this standard. People experienced care and support which met their needs and protected their rights.

Outcome 07: People should be protected from abuse and staff should respect their human rights

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. The provider had not responded appropriately to allegations of abuse.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

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.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

The provider was not meeting this standard. People who used the service were not protected against the risks of unsafe or unsuitable premises. Care was provided in an environment that was not suitably designed or adequately maintained.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

The provider was meeting this standard. People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider was meeting this standard. The provider had an appropriate system in place to regularly assess and monitor the quality of service people receive.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that 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.

A moderate impact means that 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.

A major impact means that 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.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People we spoke with told us they had a choice about how to spent their time. We were told that people were treated with respect. One visitor said " I've overheard the staff speaking with respect and care, when they can't see you even"

Other evidence
We saw that staff treated people with respect for their individual preferences. People werespoken with in a kindly manner and addressed by their first names. We saw that staff knocked on doors before entering people's bedrooms.

We observed a meal being served at lunchtime. We saw that tables were nicely set with cloths, cutlery and napkins. One of the residents helped with this. People were served in their own time and at a leisurely pace. The food was kept in a hot trolley or served directly from the adjacent kitchen. The meal was staggered so that staff had time for everyone.

There was no menu on view which might have helped some people to orientate. However, choices were offered of all courses. People who liked nothing on the menu were offered alternatives.

Two kinds of juice were offered by someone walking around with the jugs so that people unable to cope with verbal choices could see and pick. In one case the same method was used to help a resident choose her main meal, by showing her a plateful of sausage and mash and another of gammon and chips. She shook her head at both, and the carer asked if there was anything else she would prefer. She chose a sandwich. While the carer left to get this, she left the table. The carer noticed and returned to ask if she was all right. In the end she chose to have porridge in her room. This level of individual attention to detail helped ensure people's individual wishes were sought and respected.

We saw that a high proportion of residents needed help to eat their meals, from simply cutting things up to being spoonfed. In all cases, staff drew up chairs to the tables and assisted people one at a time.

We saw that some residents were demanding, either by crying out or banging on the table. Other people came into the dining room at a time of their choice and were quickly attended to. The staff were well managed so that these individuals were diverted without detracting from care given to quieter residents. We saw that one person fell asleep after her meal was put in front of her. Another resident told the carer that she was too tired to eat as she had had a bath that morning. In all cases we saw that staff talked nicely, offered alternatives and respected people's wishes as far as possible.

We inspected a sample of rooms, and saw that people's clothing was correctly labelled and rooms had personal effects and touches. We noticed that only a few bedroom doors had names on them, which might have helped people with dementia to distinguish.

Most bedrooms we looked at were clean and comfortable. However we saw that wet towels were hanging in some rooms, which felt damp and unaired. Some beds had been made without straightening the bottom sheets. One pillow case was stained. We discussed these issues with staff at the time of the inspection.

We saw that one room there was a useful sign for the resident telling her where she was, her mealtimes and when she could have a smoke. This would have been more help if there had been a clock in the room, or if she had a watch. Carers confirmed she could tell the time very well.

Our judgement
The provider was meeting this standard.. People's privacy, dignity and independence were respected.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People we spoke with were happy with the standard of service received. One said "Oh, its really lovely. I always liked mashed potato and there's plenty".

Other evidence
We saw that each resident had an individual care plan, with live documents stored on computer and corresponding hard copies in lever arch files. Nursing staff were able to update the records on laptops anywhere in the home or on the PC in the office. We saw that records were up to date and useful. Reviews were planned and happened regularly.

While care plans had an understandable clinical focus, more personal information was gathered by the activities co-coordinator who had started work on life stories.

We saw that Lakeland View Care Centre provided services for a wide group of people, with some very high levels of both physical dependency and challenging behaviours. We saw that staff knew the residents well and appeared well tuned to their varying needs.

We observed people being assisted to walk around the home, and also being hoisted. This was done sensitively despite some protests from people who clearly disliked the experience.

We saw that some residents were addicted to smoking. This was managed by keeping

all cigarettes locked in the treatment room and providing a supervised smoke on a planned hourly basis. The residents in question could not remember when they last had a cigarette, and one constantly asked for a smoke. We saw that staff patiently repeated when he could next have one.

We observed instances of residents shouting at others, and the incident book recorded numerous occasions of hitting out or throwing things. Staff generally managed these incidents well despite the limited opportunities for people to get away from each other.

We saw that the activities were planned with variety and residents needs in mind, and with clear efforts to include many people as possible at some time or another. This meant the activities staff had thought about a wide range of options both for individuals and groups. The size of the activities area, a small conservatory off one lounge restricted opportunities. On the day we inspected, we saw that activities included just sitting on the stairs and talking, a sing song and a small painting group.

Two hairdressers called each on a weekly basis, with their own client group. The home had a small dedicated hairdressing room which enabled the hairdressing to be done in privacy but which was too small to work as a wider social event. Hairdressing was clearly popular with those who chose it.

Our judgement
The provider was meeting this standard. People experienced care and support which met their needs and protected their rights.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is non-compliant with Outcome 07: Safeguarding people who use services from abuse. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
Service users were not asked to comment on this outcome.

Other evidence
Lakeland View care Centre had clear and up to date safeguarding policies which we were shown. However, these were contained in policy documents and were not easily accessible to staff. A whistle blowing statement was displayed on an exit door used by staff, but other than that staff information about safeguarding was acknowledged to be in need of improvement. We were told that the staff handbook had no section on safeguarding.

We were told at the time of the inspection that staff had received no training on safeguarding. We understood from the manager that approaches had been made to Lancashire County Council to arrange such training but that no places had been available.

There had been two notifications of safeguarding incidents in the last twelve months. The first, which related to unsafe handling of medication had been dealt with appropriately internally. The second involved an alert from a visitor made while the registered manager was on annual leave. The provider instigated an internal investigation, and notified the relevant authorities. However the alleged abuser was not immediately suspended from duty, which was contrary to the provider's safeguarding policy.

After the manager returned, which was a week after the incident took place, the matter was dealt with appropriately.

We saw that notifications regarding safeguarding incidents where residents presented dangers to each other had not been made as required by law. We checked the incident log for the month preceding the inspection visit. This recorded six incidents in which a resident had physically assaulted another, involving four different perpetrators and three different victims. One resident had been a particular target of other residents on four occasions. We advised the manager of the duty to report these incidents.

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. The provider had not responded appropriately to allegations of abuse.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

The provider is compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
Service users were not asked to comment on this outcome.

Other evidence
We inspected medication management. We looked at storage facilities for medication, the medication administration records (MAR Charts) and the prescriptions for individuals. We found that prescription instructions were correctly recorded on individual medication charts and that these matched the drugs stored for each person.

The home stored drugs in locked wall cupboards in a treatment room. Each resident's medication was stored separately in a labelled plastic box. We saw that the boxes and bottles of medication in the boxes matched the residents for whom they were prescribed.

The provider had proper processes in place for receiving medication from the pharmacy, checking it against prescriptions and then preparing the MAR charts. This work was done on a monthly basis ahead of when the drugs were needed to ensure there was time to deal with any problems.

Current medications were in one cupboard while the medication for the following month was prepared and kept in duplicate plastic boxes in a separate cupboard. Each resident's medication was kept separately in either the cupboard, or where appropriate locked in a medication fridge or in the controlled drugs cupboard.

We were told that the provider had chosen to discontinue using a medication trolley and blister packs supplied by a pharmacy. This meant each individual resident's medication had to be carried from the treatment room separately, creating extra work for nursing staff.

A few residents were prescribed medicines liable for misuse, called controlled drugs at the time of the inspection. The storage facilities in the home at the time of our inspection complied with the requirements of the Misuse of Drugs (Safe Custody) regulations 1973. We checked the controlled drugs book and the supplies in the locked cupboard and found these to be accurate, in that the drugs in the cupboard matched the records in the controlled drugs book.

While walking around the home, we saw that some prescribed drugs had been left for convenience in resident's bedrooms. This included some in a shared room. We advised the manager who agreed that this was not good practice.

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.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

The provider is non-compliant with Outcome 10: Safety and suitability of premises. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
People we spoke with recognised the building was in need of attention, but no-one was concerned by this. One person said "It's shabby, but its a big building and must be hard to maintain".

Other evidence
Lakeland View Care Centre is located in a large, old building on the outskirts of Morecambe, alongside a busy main road. The building had a neglected appearance. The sign outside the home announced that the home was undergoing a full refurbishment.

However, the manager had no maintenance or refurbishments plans to show us. He told us such planning was very much in his head. Some areas were in poor decorative condition, carpets had worn patches and there was some peeling wallpaper around a damp area on one staircase. Some rooms had a damp smell, but as there were wet towels drying in them the cause was unclear.

The flat roof over the dining room extension had been leaking for some time, plaster had fallen from the ceiling in one corner and there were some damp patches. The problem extended underneath the ceiling from the extension into the main dining area which had a pitched roof, but which was surrounded by a wide gully in need of repair.We were told by staff that the dining room roof had been a problem for some time and had a history of patching up. An estimate had been obtained by the manager for complete re-roofing, but this had yet to be agreed by the owner.

Lakeland View Care Centre was fully occupied at the time of the inspection and felt crowded. There are two main lounges one with a small conservatory off it. However there was a shortage of safe storage space, meaning corridors and peoples bedrooms were used. In one room we saw that a hoist, a wheelchair and items of furniture were stored, none of which were used by the resident herself.

The home had a small smoking room situated off the main corridor between the lounge and the dining area. This was an internal room without windows to the outside. While it had a small extractor fan, it smelled heavily of smoke and the door was propped open throughout our visit. This was not a suitable location. It was also an unhealthy environment for staff supervising the smokers.

There was no safe, usable outdoor space for residents. The front of the building had a small car park, adjacent to a busy main road. At the back, there were some pieces of garden furniture but we were told they were never used as the outdoor area had a steep drop and was unfenced.

The small building meant that it was harder for residents to get away from others who could be annoying because of their conditions. The activities room was restricted to a small conservatory.

Our judgement
The provider was not meeting this standard. People who used the service were not protected against the risks of unsafe or unsuitable premises. Care was provided in an environment that was not suitably designed or adequately maintained.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
People we spoke with spoke highly of the staff and said they were kind and attentive. One said "It couldn't be nicer".

Other evidence
At the time of the inspection, there were three nurses and six care staff on duty, as well as the manager and an administrator. One of the nurses was accompanying a resident to hospital at the time. These staff were organised in teams looking after groups of residents. Additionally there were two activities co-coordinators, three domestic staff and a cook.

Staff we spoke with told us they were regularly supervised and well trained. We confirmed this by looking at supervision notes and training records. We saw that induction packs followed a clear pattern and built up skills and knowledge over the first three months of the staff members employment. We saw that senior staff had taken on special area for learning and training internally by cascading their learning. One example was dementia awareness.

Supervision notes we saw were helpful and clear. However there were a few gaps in the supervision matrix and management should assure themselves that all staff have access to regular individual supervision.

We were told that regular staff meetings were held but the last one minuted was in October 2011. There was a staff handbook, but the manager told us it was "woefully out of date" and he preferred not to have it read.

Our observations of staff working demonstrated that they worked well as teams, with clear management direction about their roles on the day. This included both care staff, domestic staff and the activities co-coordinators. We saw that where necessary, staff were deployed to give one to one attention to people with challenging behaviour. Good staffing ratios meant staff were able to manage well and residents were cared for in a safe manner.

Our judgement
The provider was meeting this standard. People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
Service users were not asked to comment on this outcome.

Other evidence
The provider used a range of methods for ensuring that quality standards were maintained in the home.

We saw that the manager was hands on and available, and were told issues were dealt with on the spot. However, no records were kept, meaning it was difficult to judge the effectiveness of his "walking the floor".

We saw told that a number of internal audits were conducted, and saw up to date audits for laundry, cleaning, medication, pest control and fire safety.

Senior nurses reviewed care plans of at least 4 patients a month. We saw documents detailing the outcomes for the reviewed nurse. These were graded on a traffic light system meaning any serious issues were reviewed again after a month

We saw that these audits gave praise as well as noting areas requiring attention. Areas looked at ranged from clinical recording to the use of deprivation of liberty safeguards. One noted the need to be more reflective about practice standards.

We saw that a food surveys were conducted, the most recent being on 21st June 2012, by senior care staff. These covered variety, tastiness, presentation, choice, warmth and

how comfortable the dining room was. Most people were unable to respond because of their conditions. However those who were able gave positive feedback.

Other than this, Lakeland View Care centre did not make use of surveys of residents or their visitors and management might like to note that this would provide additional information to improve quality standards.

Overall we found the management and staff open to improvement and willing to learn from inspection and other sources.

Our judgement
The provider was meeting this standard. The provider had an appropriate system in place to regularly assess and monitor the quality of service people receive.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: 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. The provider had not responded appropriately to allegations of abuse.	
Diagnostic and screening procedures	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: 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. The provider had not responded appropriately to allegations of abuse.	
Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met:	

	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. The provider had not responded appropriately to allegations of abuse.	
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: People who used the service were not protected against the risks of unsafe or unsuitable premises. care was provided in an environment that was not suitably designed or adequately maintained.	
Diagnostic and screening procedures	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: People who used the service were not protected against the risks of unsafe or unsuitable premises. care was provided in an environment that was not suitably designed or adequately maintained.	
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: People who used the service were not protected against the risks of unsafe or unsuitable premises. care was provided in an environment that was not suitably designed or adequately maintained.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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

The provider's report should be sent to us within 7 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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