Blackcliffe Limited

The Lakes Care Centre

Inspection report

Off Boyds Walk
Dukinfield
Cheshire
SK16 4TX

Tel: 01613302444
Website: www.lakescare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Lakes Care Centre is a care home. It is registered to provide personal and nursing care for up to 77 people aged 65 and over across three units. One unit provides nursing care whilst the other two units provide residential care. All units have single bedrooms, and there are a range of communal spaces.

People's experience of using this service and what we found
People were not always safe as action was not taken to consistently identify, assess and mitigate risk. This included both individual risks and needs, and environmental risks. Systems for supporting people with their medicines were not safe and people did not always have the medicines they needed. Accurate medicines records were not being consistently maintained. There was not always enough staff to meet people's needs and good infection prevention and control procedures were not always being followed. Systems to learn lessons were not always effective.

The service had not taken reasonable action to make enough improvements since the last inspection. Enforcement action and recommendations from the last inspection had not been addressed and there were multiple repeat breaches of regulation. We were not assured that the provider was able to identify, address and sustain improvements. Record keeping and systems of checks were not consistent to ensure good governance. Lessons were not being effectively learnt to mitigate future risk of avoidable harm for people. The service was working with the local authority and clinical commissioning group to make improvements across the service following recent concerns.

Peoples' care needs were not consistently assessed and did not always contain detailed person-centred or accurate information. People were not always supported to eat suitable healthy and balanced diets and many people told us they were unhappy with the quality of food. Staff felt well supported in their role, but relevant training was not consistently completed, and assessments of staff's knowledge and competency was not always in place. There had been limited improvements to the environment since our last inspection. People were referred to relevant health care services when needs were identified.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Records regarding the assessment of decision specific mental capacity and best interest decisions were not consistently recorded and there were not sufficient systems for oversight in place.

The provider did not demonstrate that people were well cared for through taking effective and timely action, such as addressing shortfalls from previous inspections, issues within the environments and acting on the feedback of people, for example regarding food and activities. People spoke positively about the care team and we saw staff were generally kind and caring although staff were often task focused. Records did not consistently reflect people's preferences or how to promote independence and we saw examples where

people's dignity and privacy was not respected.

People did not always receive person-centred care and care records did not consistently reflect individual's needs and preferences. People told us they were bored and there were not enough activity coordinators to provide personalised activities which were socially and culturally relevant to people. The service had begun work to develop advanced care plans with people but, at the time of the inspection, people's records did not capture their end of life care wishes.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 19 August 2021) and there were multiple breaches of regulation. The provider did not return a completed action plan after the last inspection to show what they would do and by when to improve as requested. At this inspection we found the necessary improvements had not been made and the provider was in continued breaches of multiple regulations and breach of additional regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the management of medicines, the quality of care being provided, staffing levels and systems of oversight at the service. A decision was made for us to inspect and examine those risks.

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

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

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

We have identified continued breaches in relation to the management of people's medicines, the assessment and management of individual and environmental risk, developing and delivering individual plans of care, having enough staff to meet people's needs, oversight and governance of the service at this inspection. We found new breaches in relation to providing suitable healthy and balanced diets, ensuring the environment is suitable for people's needs, and care and treatment provided with the consent of the relevant people and in accordance to the Mental capacity act (2005).

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe., and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

The Lakes Care Centre

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was completed by two inspectors, a medicines inspection manager, a nurse specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Lakes Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. A new manager was in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We obtained information from

Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We visited the service and reviewed staffing levels and walked around the building to ensure it was clean and a safe place for people to live. We spoke with 12 people who used the service and six family members about their experience of the care provided. We spoke with 21 members of staff including the head of quality, the new manager, unit managers, nurses, care workers and auxiliary staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We used the 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. We reviewed a range of records including 15 people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were examined.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection we found systems were not robust enough to demonstrate safety was effectively managed. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Repeated concerns about the handling of medicines had been seen at our last three inspections.
- In the previous month, several people did not get their prescribed medicines as stock had not been received in time.
- Checks on several medicines showed they had been missed and had not been given as prescribed.
- Prescribed fluid thickeners to help people with swallowing difficulties were not always being recorded accurately, so we could not be sure they were being used safely. These thickeners were not always being safely stored.
- One person was given too much Paracetamol which placed them at unnecessary risk.
- Medicines that were required to be given at specific times were not always given safely, as there was not an effective system in place to make sure appropriate time intervals between doses were observed.
- Records for applying creams were not consistently completed so we could not be sure people were having them applied properly.
- Medicines patches for one person were not always safely applied, as the system in place to make sure the place of application was rotated properly, was not effective.
- Medicines for disposal were not always safely stored.
- Audits were in place, but these had not always identified the concerns found during this inspection.

People's medicine was not being properly and safely used. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is the fourth consecutive occasion the service has been in breach of this regulation.

- There was a new home manager in post and new nurses had been recruited to support work in the nursing unit. The service continued to work collaboratively with the local authority and clinical commissioning group.

Assessing risk, safety monitoring and management

At our last inspection we found individual and environmental risks were not being consistently monitored and reviewed to ensure people's safety. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Checks of the environment were not sufficient to identify potential hazards, ensure action was taken and lessons learnt across the service. There were several examples across the service where furniture was not suitably secured, including radiator covers which were either not secured or not in place to reduce the risk of people being scalded.
● People had individual risk assessments in place. However, these were not always accurate and reflected in people's records of care. Each unit had different systems for recording and managing risk and we were not always assured that the service had taken appropriate action in a timely way to respond when risk had been identified. One unit had recently reverted to paper records to ensure high risk issues, such as skin integrity and nutritional guidance, could be clearly accessed and monitored.
● Staff were following different processes when reporting accidents and incidents. We were not assured that, where people had not been injured following a fall, consideration had been given to ways to prevent future risk. There was no clear oversight of themes and trends to enable lessons to be learnt for individuals and more widely across the service.
● People were not being consistently protected from known risk. We found examples where people who were at a falls risk were not subject to the necessary levels of supervision or checks to reduce the risks. There were occasions when people were transported in wheelchairs where lap straps were not used to prevent the risk of them falling out, and we could not be certain that people at risk of pressure damage were having the appropriate level of pressure relief.

Risks to people were not being assessed and action taken to reduce this as much as possible. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was responsive to the feedback given and recognised the challenges as described above. However, we need to see they can progress any assurances given, and evidence that improvements are followed through and sustainable in the long term.

Staffing and recruitment

At our last inspection we found there was not enough staff deployed. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● There was not enough staff to meet the needs of the people living at the service. Since our last inspection we had received numerous concerns that there was not enough staff. The service had completed a survey which had identified various concerns, including around staffing levels. Feedback from people and staff consistently raised staffing levels as an area of shortfall.

● People told us they often had to wait for assistance from staff. One person said, "Sometimes I have to wait five or ten minutes [for assistance], sometimes I'm forgotten about." and several people commented they had not had a bath or shower recently. Records indicated people were mainly supported to have washes rather than baths and showers. Records also indicated people were not receiving the frequency of checks and pressure relief they needed, and we observed people who were immobile were sometimes left sitting for extended periods of time.
● Staff were very busy and not always able to provide meaningful stimulation or activities to people living at the service. We observed various occasions where people who were a falls risk or who could become agitated without reassurance were left without the appropriate levels of support or frequency of checks, as staff were busy in other areas of the building. Staff were not always able to complete tasks, such as paperwork, due to competing immediate demands including covering staff breaks and days when the service was short staffed; dealing with phone calls and requests for information; and following up on actions such as updating GP and social workers. Many senior staff told us they did not have enough time to do the required tasks relevant to their role such as reviewing and updating care plans.

There was not enough suitably qualified, competent, skilled and experienced staff in place across the service to meet people's needs. This demonstrates a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider gave assurance that staffing had been increased on one unit and a more robust dependency tool had been completed to ensure sufficient staffing levels. This will be reviewed at our next inspection.

Preventing and controlling infection
● Staff did not always wear personal protective equipment (PPE) appropriately. Good infection prevention and control practice varied across the service. The majority of staff had completed training in this area.
● Appropriate disposal procedures for used equipment were not always being followed. For example, we observed used continence products left on people's bedroom floors before being disposed of, and hazardous equipment was not always securely bagged and disposed of in the appropriate bin quickly.

The prevention, detection and control of the spread of infection was not implemented effectively. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The home was following the current guidance regarding testing and managing visiting arrangements. People and staff were being supported to access the Covid-19 vaccination programme.
● Staff had access to training on infection prevention and control and Covid-19. There was a policy in place and the new manager had a good understanding of the current government guidance.

Systems and processes to safeguard people from the risk of abuse
● People were not always kept safe. We noted there had been numerous recent safeguarding investigations. These included the management of pressure injuries and shortfalls in medicines administration, where people had been left without the medicine they were prescribed, and it was not evident that any action had been taken. The management team and staff were working with external agencies to investigate and learn from these concerns.
● There were policies and procedures in place to safeguard people and most staff had completed recent training in this area.

Learning lessons when things go wrong

● The systems to ensure lessons were learnt when things went wrong, were not always effective and shared across the service. It was not evident that lessons were learnt from previous safeguarding investigations.

● The systems for oversight of accidents, incidents and safeguarding's were not clear and it was not evident that the provider had sufficient oversight to ensure appropriate action was taken. For example, where we found records of an accident having occurred, there was no evidence to indicate consideration to mitigate future risk and update care records had occurred.

● The new manager, nominated individual and management team told us they were committed to making the necessary changes to learn lessons when things had gone wrong and drive improvement across the service. We will review progress at our next inspection to assess whether action is implemented effectively and sustained over time.

Inadequate

Is the service effective?

Our findings

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At our last inspection we found systems for ensuring people's care and treatment was appropriate, met their needs and reflected their preferences was not being used effectively. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is discussed in the responsive section of this report.

● The needs of people were not consistently assessed and reviewed by staff with care plans updated to reflects and meet individual's needs. The quality of assessments and care plans varied across the service. There were examples where detailed initial assessments were not in place, and current assessments of need had not been updated to reflect current needs or additional information known.
● Assessments and care plans were not consistently detailed, and person-centred. There were examples where information was inconsistent and confusing. There was limited evidence to demonstrate people and families had been involved. People were not clear about how they had been involved in the assessment and care planning process.
● There were no consistent systems for recording information and maintaining accurate records of people's needs and any changes. One unit had recently introduced paper records to ensure oversight of specific care needs, such as wound care, as a temporary measure.

Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection we recommended the provider review the mealtime experience and consider how choice and good practice guidance can drive improvements in ensuring people have a balanced and healthy diet. Not enough improvement had been made in this area.

● People were not being supported to have healthy, balanced and nutritional meals. Menus did not demonstrate that consideration had been given to people's preferences or creating meals that were nutritionally balanced. People did not speak positively about the food being provided and one person said, "It's terrible food, it really is."
● People were not consistently aware they could ask for alternative options if they did not like what was on the menu. One person said, "If I don't like it, I don't eat it. There's no choice … I do get a little hungry in my tummy." However, another person said, "You have a choice, what I have is what I like." There was no consistent evidence that when people did not like the choice of meal an alternative option was offered, and this was not observe during the inspection.
● People did not consistently receive food that had been prepared in line with their needs. We could not be sure the kitchen staff knew how to provide diets appropriately modified in line with Speech and Language

therapy assessments and this was raised with the management team.
● People's weight loss had not been consistently monitored since the last inspection. Following recent concerns, the service had undertaken some work in this area and had better oversight of people who had been losing weight. However, this was not always reflected within care plans and there was a lack of detailed and person-centred information about how to improve people's dietary intake.

People's nutritional and hydration needs were not always being met with the provision of a suitable healthy and balanced meal which was in line with people's assessed needs and preferences. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Following the inspection, the provider told us a new menu was being developed and trialled with variety of choices and options. We will review this at our next inspection.

Staff support: induction, training, skills and experience

At our last inspection we recommended the provider review processes for induction, training and checks of competency and support, to ensure they are effective in providing staff with the skills and knowledge they need to complete their role. Not enough improvement had been made at this inspection.

● Staff did not always have the training and support they needed to undertake their role. We found that staff did not consistently demonstrate a good understanding of how to reduce risk and escalate concerns effectively. There was no evidence of competency assessments, for example with moving and handling or donning and doffing PPE.
● Staff had not consistently completed all the relevant mandatory training. There were plans for improving training, which included training additional staff to deliver training in house, such as moving and handling. Staff told us they had to complete training in their own time as provision to complete training whilst in work was not possible due to staffing issues.

Staff were not consistently receiving appropriate support, training, professional development, supervision and appraisals as necessary to enable them to carry out their duties. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff felt supported in their role by their line manager, although this varied across the service. One staff member told us, "My unit manager is brilliant; they are so supportive." However, other staff raised concerns about staffing levels and said the staff morale in the service was low.

Adapting service, design, decoration to meet people's needs

At our last inspection we recommended the provider ensure that the views of people living at the Lakes Care Centre, as well as good practice guidance for those with specific needs, such as dementia, are considered when developing the action plan for improvement to the premises. Not enough improvement had been made at this inspection.

● At our last inspection we were told the management team had identified the shortfalls in the decor and a programme of redecoration across the service was planned. We found little evidence that expected progress had been made since that inspection. The nominated individual assured us that work was due to commence shortly. We will review this at our next inspection.
● Some areas were not accessible for people to use. For example, several bathrooms were being used for

storage of resources and equipment and therefore not available for people to access. Several people told us they had not had a bath or shower recently and indicated this is something they wanted. We found other areas, such as the sluice, cleaning cupboards and external doors were not consistently suitably secure and raised this with the management team to be addressed.

● At our last inspection we found the storage of equipment was not always sufficient or used effectively, for example moving and handling equipment. At this inspection we found limited improvements had been made. We discussed this with the nominated individual who advised there were plans to extend the outside storage units available

● We found examples of shortfalls in the safety of the environment such as the security of furniture and radiators. We found similar issues at our last inspection. The management team assured us that action would be taken to address these concerns.

The premises and equipment were not always suitable for the purposes being used, and properly used and maintained. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People had assessments of their capacity. However, it was difficult to ascertain how meaningfully these had been completed and records were inconsistent and often lacked detail.

● Where people were assessed as being subject to restrictions appropriate application for DoLS were made. Records did not clearly demonstrate where DoLS had been granted, or that any outstanding DoLS or DoLS that required renewal of application were identified in a timely way.

● Decision specific capacity assessments and best interest decision making was not consistently or clearly recorded. It was not clear how the relevant people for those who lacked capacity, such as families or advocates, were involved.

● Staff lacked confidence in their understanding of mental capacity and DoLS. A nurse with experience in this area was new to the service and was working to review and improve the paperwork in place at the time of inspection.

People's care and treatment was not being consistently provided with the consent of appropriate people and in accordance of the Mental Capacity Act 2005. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People were referred to healthcare services when needs were identified. However, records did not demonstrate these were consistently completed in a timely way, that any issues were followed up and that information was effectively incorporated in to care plans. For example, advice regarding pressure relief and

moving and handling assessments had not been implemented in care plans, which could lead to people not receiving appropriate care.

● People were supported to attend medical appointments as needed. One person told us, "Yes they would [get me a doctor if needed]."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- The provider did not always take effective action to ensure that people were well treated and supported through taking timely action. For example, People who would have liked to have more frequent baths and showers were unable to do so as communal bath and shower rooms were not in use and staff were too busy to consistently provide this level of care. People complained of being bored and at our last inspection we reported similar findings under 'staffing and recruitment' in the safe domain.
- People generally told us they were treated well by staff and we observed kind and patient interactions between staff and people. One person told us, "Since I have been here, I have been treated with respect and kindness. I am very happy." Another person noted, "They can be abrupt, when they don't have time, but they are not uncaring."
- Whilst people's experience of care was generally positive, some people told us that certain staff could be rough when supporting them. Where we had specific information, this was shared with the management team for further investigation. Some people told us they did not always get the care they wanted. Certain aspects of care, such as the delivery of personal care and administration of medicines was not always person-centred and was often focused around the needs of the service.

Supporting people to express their views and be involved in making decisions about their care

- People's preferences were not clearly reflected in care records and people did not always feel that staff knew their likes and dislikes. Records, including reviews, did not consistently demonstrate that discussions with people and their families about their care had taken place.
- The provider had completed surveys with people living at the home. However, it was not clear what action had been taken in response to this. The nominated individual advised us that the planned redecoration on one unit had been designed with the feedback and input of the people living on this unit.

Respecting and promoting people's privacy, dignity and independence

- People were not always encouraged to be as independent as possible. Care records did not always clearly detail what people could and could not do for themselves or give staff specific guidance on how to support people to maintain their independence. However, staff we spoke with demonstrated an understanding around how to promote independence.
- People were not always supported to maintain their privacy and dignity. We saw occasions when personal care was delivered without people's bedroom doors being closed. People's experience of privacy and dignity varied across the service. One person told us, "Staff never come through the door without knocking."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last focused inspection, we found the systems for ensuring people's care and treatment was appropriate, met their needs and reflected their preference was not being used effectively. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was reported under the key question of Effective at that inspection.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● People's care plans lacked person-centred information and detail about preferences and wishes. The quality of care plans varied across the service, but many lacked specific information about the person and their individual needs and preferences'.
● Staff understood people's needs but did not consistently have a good understanding of people's preferences. Staff told us they could not access people's care plans and the information they knew about people came from handover information and word of mouth. We spoke to the nominated individual who advised that staff could access electronic care plans. They assured us that, although this system had been in use in the service for some time, they would implement additional training for staff in this area.
● People were not able to tell us how they had been involved in personalising their care plans. Records did not consistently demonstrate people and families had been involved in developing care plans and reviews of care.

Systems for ensuring people's care and treatment was appropriate, met their needs and reflected their preferences was not being used effectively. This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The new home manager understood the accessible information standard and how to provide information to people in a way they could understand. They told us they could adapt information to meet individual needs and would arrange for adapted formats and translation services as needed.

● People's communication needs were assessed, and care plans in place. The detail varied across the service, with good examples including specific details of how staff can effectively communicate with people, but other examples lacking any detail.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People lacked stimulation and several people told us they were bored. One person told us, "There aren't really any activities. We did have skittles a few days ago, it was fun but most of the time they [staff] are too busy."

● One staff member brought their pet into work. We observed people responded positively to the presence of this pet and enjoyed having this animal around.

● People were not being consistently supported to access activities that were relevant to them. One person told us their religion was important to them and they would like to go to church and said, "No-one's ever offered to take me, and a priest does not come in." A relative told us, "My [family member] likes watching sports and has a TV in their bedroom. I've visited and the TV's not been on, in fact I had to set it up and tune it in myself."

● People living at the home were able to complete projects with some youth groups as part of a community development programme. We were told that this had included a variety of crafts when the current restrictions, due to the Covid-19 pandemic, allowed.

● There was one activity coordinator who covered all units and therefore had limited time to offer activities either in groups or one to one. They had arranged a couple of Christmas activities but were often used in other roles, such as supporting people to hospital appointments. The nominated individual told us they were recruiting additional activity coordinators to develop activities in the service. The management team acknowledge that several community links and activities had been affected by the current pandemic and that this was an area for development.

Improving care quality in response to complaints or concerns

● People's experience of how the service responded to complaints varied. For example, several people were unhappy with the quality of the meals and a survey about mealtimes had been completed. There was no evidence to demonstrate what action had been taken in response to this and people were still unhappy about the mealtime provision. However, a relative gave an example where they had raised a concern, and this had been quickly remedied.

● There was no record of any recent complaints to the service but there were some thank-you cards that had been recently received from families of people living at the service. A relevant complaints procedure was in place.

End of life care and support

● The management team were working with people and families to develop advanced care plans. However, these were not yet in place for many people. When people did not wish to have these discussions, this was respected by staff.

● The service had recently recruited a nursing team with significant experience in end of life care. They were keen to improve this area of care within the service and had a good understanding of best practice.

● Training regarding end of life care was in place, but a number of staff had not yet completed this.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

At our last inspection we found systems were not robust enough to have identified and remedied the issues we found on the inspection in a timely manner and that limited progress had been made to drive improvement and respond to the concerns found at the previous inspection. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The service has been rated as requires improvement for the past four inspections. We have found repeat breaches of regulation which include repeat issues with the management of medicines and processes for oversight. Since our last inspection there are repeat breaches of four regulations which include regulation 9 (Person-centred care); regulation 12 (Safe care and treatment), regulation 17 (Good governance) and regulation 18 (Staffing). We were not assured that the provider is able to identify, address and sustain improvements within the service, and previous enforcement action taken by CQC has not led to the necessary improvements.
● We had not received an action plan following the last inspection. An action plan is requested from the provider when we have found breaches of regulation to demonstrate what the providers plans to do to improve the service and meet the breaches of regulation.
● At our last inspection we made numerous recommendations, including around meeting people's nutritional needs, staff training and support, and the premises. At this inspection we did not find the expected progress had been made to introduce the improvements necessary in these areas.
● There were no clear systems to demonstrate lessons were effectively learnt. We were not assured that the provider had systems for oversight and there was a lack of consistency across the service, with different areas of the service using different processes.
● Following recent concerns an action plan developed with the local authority and clinical commissioning group was in place and being progressed. However, the provider needs to demonstrate that learning and improvement can be completed, embedded and is sustainable.

We were not assured that the provider was able to identify, address and sustain improvements within the service through sufficient oversight and suitable governance arrangements. This was a continued breach of

regulation 17 (Good governance). This is the fourth consecutive occasion the service has been in breach of this regulation.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● A new nursing team was in place on the nursing unit. These nurses had a clear understanding of good practice and were keen to improve the service and implement appropriate and robust processes. The other units had a more established team of staff. We noted processes and practices varied across all units in the service. Systems for oversight, including checks and audits, were not being completed consistently and the quality of these checks varied.

● There had been several changes in home manager since our last inspection. There has not been a manager registered with CQC for the past five months, although there was a new home manager in post. It is a condition of registration for The Lakes Care Centre to have a registered manager in post.

● The home manager and management team appeared to be submitting notifications about significant incidents which affect the service and following legal responsibilities under the duty of candour as required. It was difficult to establish that regulatory responsibilities were consistently being met due to inconsistent record keeping and lack of provider oversight. One relative commented that, "Staff don't always share information about my [family member]. I feel like they put on a solid front." Another relative described staff as being "guarded" and told us communication could be much better.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People did not consistently get person-centred care. We noted care records were not always individualised and person-centred, or people's preferences followed. There was limited evidence to demonstrate how people and their families had been involved in developing plans of care. People were not aware of any meetings or surveys being in place and gave examples where they had not received the care they wanted.

● People and families did not all know the new home manager. However, those who did spoke positively about them and one person said, "I think there is a manager and they are very good. I've seen the manager five or six times. They are very polite."

Working in partnership with others

● The home worked with a variety of health care professionals and was working with the local authority and clinical commissioning group following recent concerns.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Systems for ensuring people's care and treatment was appropriate, met their needs and reflected their preference was not being used effectively. Regulation 9 (1) (3).

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Care and treatment of people was not being consistently provided with the consent of appropriate people and in accordance of the Mental Capacity Act 2005. Regulation 11 (1) (3).

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risks to people were not being assessed and mitigated as much as reasonably practicable. People's medicine was not being properly and safely used. The prevention, detection and control of the spread of infections was not implemented effectively. Regulation 12 (1) (2) (a, b, g, h).

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs were not always being met with the provision of a suitable healthy and balanced meals in line with people's assessed needs and preferences. Regulation 14 (1).

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premise and equipment was not always suitable for the purposes it was being used and properly used and maintained. Regulation 15 (1) (c, d, e).

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance We were not assured that the provider is able to identify, address and sustain improvement within the service through sufficient oversight and suitable governance arrangements. Regulation 17 (1) (2) (a, b, c, e) (3).

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was not sufficient numbers of suitable qualified, competent, skilled and experienced persons deployed to meet the needs of people living at the service. Staff were not consistently receiving appropriate support, training, professional development, supervision and appraisals as necessary to enable them to carry out their duties. Regulation 18 (1) (2) (a).

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.