South West Care Homes Limited

Lake View

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place over one and a half days on 5 and 6 November. The first day was unannounced.

The home was last inspected on 26 June 2013 when the provider met the regulations we inspected against.

Lake View is a residential care home which provides personal care for to up to 29 older people, including those with dementia or learning disabilities. Two people lived more independently in a detached bungalow, but also received personal care from staff working at the service. On the day of our inspection there were 22 people living at the home. Lake View does not provide nursing care and people who live at Lake View access healthcare through local community health services. The home is owned by South West Care Homes Ltd, which operates 10 residential care homes in South West England.

There was a registered manager in post at Lake View. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We walked around the building and found some areas that required attention. For example, some carpets were ripped. Some areas, such as the entrance hall were in need of redecoration. The provider had produced a plan to deal with any environmental issues.

Some people living at the home felt there were not enough staff on duty to meet their needs.

Medicine management was not entirely safe. Not all entries on record charts were double signed to ensure the correct information had been recorded. Other aspects were found to be sufficient, including the administration of medicines.

Improvements were needed to ensure people's capacity to make decisions was appropriately assessed and the way in which they were asked for their opinions on the quality of care provided. People's capacity to make decisions for themselves had not been assessed.

You can see what action we told the registered provider to take at the back of the full version of the report.

People told us they felt safe. Staff had received training in safeguarding people from abuse. Staff also received some relevant training to enable them to meet people's needs. However, no training in caring for people with dementia had been provided.

People were asked for their consent before staff provided any personal care. Healthcare needs were met by visiting professionals. Health and social care professionals that we spoke with had no concerns over the care being provided by the home.

There was a robust recruitment procedure in place. This minimised the risk of recruiting staff who may be unsuitable to work with vulnerable people. We saw good interactions between staff and people living at the home. Interactions were professional, caring and friendly. Where staff identified people's personal care needs they responded promptly. People told us they enjoyed a range of activities including musical entertainment and visiting animals.

Care plans contained some confusing information. However, staff knew people's needs and we saw that people's needs were met in a personalised way. We saw a range of risk assessments and these showed the measures that were taken by the home to reduce any risks.

People's views were not regularly obtained about the quality of care provided and they were not always involved in planning their care. While people knew who to complain to, there was no recorded evidence the complaints had been dealt with.

The registered manager had been in post for just over a year. The registered provider carried out a number of audits to enable them to measure the quality of the service being provided. Where shortfalls had been identified action plans had been produced in order to address the issues.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

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?
The service was not safe.

People told us that staffing levels were not always sufficient to effectively meet their needs.

Medicine administration records were not always completed correctly.

People had and emergency evacuation plan, but these needed more detail

A range of risk assessments had been completed and control measures had been identified to minimise the risks.

Requires Improvement

Is the service effective?
The service was not effective.

Improvements were needed in relation to staff training in caring for people with dementia.

The environment needs improvement to make it more suitable for people living with dementia.

Improvements were needed to ensure people's capacity to make decisions was appropriately assessed.

People's capacity to make decisions for themselves had not been assessed.

People received care that met their healthcare needs from staff and visiting professionals.

Requires Improvement

Is the service caring?
The service was caring.

People who displayed agitated or repetitive behaviour received care from staff who were caring and patient.

People were asked throughout the day if there was anything they wanted or needed

Good

Is the service responsive?
The service was not responsive.

People had an individualised care plan that gave staff directions on how their needs should be met. However, some of the information was not accurate.

Staff were seen to recognise people's needs and meet them in an individualised manner.

Requires Improvement

Summary of findings

One person living at the home felt that sometimes they were 'fobbed off' when they raised concerns, and there was no evidence that complaints had been dealt with.

People were not routinely asked for their opinions on the quality of care provided.

Is the service well-led?

Requires Improvement

The service was not well led.

There was no system in place to regularly review the quality of care being provided. A new audit system was in place but this had not identified some issues with care plans.

Staff were clear about the values of the home and felt supported by the registered manager.

Lake View

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 registered provider was 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 5 November and 6 November, the first day was unannounced. One Adult Social Care inspector undertook this inspection.

Prior to our inspection we had received some concerns about the attitude of staff towards one person who lived at the home and about the maintenance and cleanliness of the building.

Before the inspection visit we gathered and reviewed information we hold about the registered provider. This included information from previous inspections and notifications (about events and incidents in the home) sent to us by the provider. During our visit we spoke with five people using the service, two visiting relatives, three care staff and the registered manager. We also spoke with the registered provider's representatives who oversaw and supported a group of homes owned by the registered provider. Following the visits to the service we spoke with two health and social care professionals and staff from the local authority who have commissioned some placements for people living at the service.

We observed the interaction between staff and people living at the service and reviewed a number of records. The records we looked at included the registered provider's quality assurance system, accident and incident reports and staffing rotas. We also pathway tracked three people living at the service. This involved looking at people's individual plans of care and wherever possible speaking with the person and staff who care for them. This enabled the Commission to better understand the experience of people living at the service.

Requires Improvement

Is the service safe?

Our findings

During this inspection we found that improvements were needed to the environment and the way some medicine records were maintained. More information was needed on risk assessments and more attention was needed to the way infection control was managed. There were not always enough staff on duty.

People were at risk of falling because two bedrooms had rips in the carpets that could be a trip hazard. The registered provider told us there were plans to replace one of the carpets and repair the other.

We looked at the way medicines were managed. Although not all handwritten entries on the Medication Administration Record (MAR) chart were signed by two people to ensure the correct information had been recorded, we observed medicines being administered and saw good systems in place. Staff who administered medicines were careful to ensure medicine was taken by each person before signing the record sheet to say it had been given. There were samples of staff signatures and initials available which meant it was possible to see who had administered a particular dose of medicine. One person told us they always got their medicines on time and when they needed them.

We looked at the way risks to individuals were assessed and managed. People's Personal Emergency Evacuation Plans (PEEPs) did not contain information about whether the individual could hear the fire alarm or if they would react to it. This meant staff may not have all the information they needed on how to safely evacuate people if required. Other risk assessments contained good details of how to reduce risks. For example, risks relating to nutrition, pressure areas and behaviours that could be difficult for staff to manage had been assessed. Where risks had been identified there were control measures in place to reduce risks. For example, where people had been identified as being at risk from pressure sores, pressure relieving equipment was being used. Equipment in use at the home was well maintained and serviced in line with the manufacturer's instructions.

One person told us they had 'lost' a bar of chocolate as they could not lock their bedroom door and other people wandered in. They also said that a lot of their clothing went missing when it had been sent to the laundry. However, they told us they felt safe at the service. Another person told us they "definitely" felt safe at the service.

Three people living at the service told us they felt there were not enough staff on duty. One told us this was because there were not enough staff around to prevent other people going into their bedroom. The second person told us they felt there wasn't always enough staff on duty because sometimes they had to wait a while to get the help they needed. The third person also told us they felt they didn't always get the help they needed, especially at night. They said they felt there was "definitely not" enough staff on duty and that sometimes they had waited 15 minutes for their call bell to be answered. One relative told us they felt staffing levels were not always sufficient to meet people's social needs. They told us their relative spent much of their time alone in their room because staff did not have time to spend with them.

We spoke with one healthcare professional who told us they had some concerns over the number of staff on duty, particularly at night, when there was one staff awake and one sleeping in. Staff told us that they felt there were enough staff to meet people's physical care needs, but there was little time to sit and chat with people.

We discussed staffing levels with the registered provider who told us the levels set were all that the local authority funding levels allowed. They said the local authority funding did not allow for 'social care' needs. The registered provider told us that a 'dependency tool' was used to calculate the numbers of staff needed to meet people's assessed needs and that the staff rotas were developed based on these numbers. There were three care staff on duty including a team manager all day, with an additional staff member on duty in the morning to assist with getting people up. The registered manager, a cook and cleaner were also on duty. The registered manager told us they felt this was sufficient and there was the possibility to increase staffing levels when people's needs increased. On both days of our visit we found there were sufficient numbers of skilled and experienced staff to effectively meet people's needs.

People were not entirely protected from the risks of cross infection as we saw one chair in the lounge had a large rip in it, making it difficult to keep clean. However, the rest of

Requires Improvement

Is the service safe?

the service was clean and we saw domestic staff cleaning the home during our visit. Staff had easy access to disposable gloves and aprons and they told us they had received training in infection control.

Prior to our inspection we had received concerns that staff appeared to be 'uncaring' towards one person living at the home. We had asked the registered provider to look into this and they sent us information about their investigation. This included details of the person's care plan and the directions given to staff on how the person's needs were to be met. They had found no evidence to indicate staff had acted inappropriately. Throughout the course of our inspection we observed staff interacting with this person. All the interactions we saw were respectful and caring. Staff spent time reassuring the person and attending to their needs in a manner detailed within the person's care plan. The person continually asked staff the same questions and staff always answered respectfully and patiently.

Staff demonstrated a good knowledge of different types of abuse. They told us how they would recognise abuse, and what they would do if they suspected abuse was occurring within the service. They said initially they would tell the registered manager, but knew they could also contact the police or the local safeguarding team. Staff told us and records confirmed that they had received training in this area. The registered manager was aware of their duty to report any allegations of abuse to the local authority safeguarding teams.

People were protected by robust recruitment procedures. The registered provider had a policy which ensured all employees and volunteers were subject to the necessary checks which determined that they were suitable to work with vulnerable people.

Prior to our inspection we had received some concerns about the state of repair of the building. These included the dining room flooring, a drain cover in the car park, and the rendering on a chimney in the car park. We had written to the registered provider about these concerns and in response they had brought forward the replacement of the dining room floor covering. The drain cover had been replaced and a building contractor had visited to confirm the rendering on the chimney was safe. We had contacted the local Environmental Health Officer and asked them to visit the service. They have visited since our inspection and have told us they are happy with the remedial work carried out by the registered provider.

Requires Improvement

Is the service effective?

Our findings

We found that some improvements were needed in relation to staff training, the environment and mental capacity assessments. For example, Lake View is a service that cares for people with dementia but staff told us they had not received any training in this area. The registered manager told us they had recently received dementia care training, and planned to pass this on to staff. However, we saw that the needs of people with dementia were being effectively met by staff. Staff were patient and kind repeating information and requests slowly in order to give people a chance to process the information.

A visitor told us one of the reasons they had decided to bring their relative to the home was because the staff had been so friendly and nice, and were able to deal with their relative's behaviour. They told us "They [staff] just get on with it".

The registered manager used a training matrix to identify what training staff had received and when updates were needed. They told us this helped them ensure staff had the training they needed. However, the lack of training in caring for people with dementia had not been identified as a priority.

People's health and personal care needs were effectively met by staff who had received training in areas such as Pressure Ulcer Prevention (PUP) and dental hygiene. New staff confirmed that they had received an induction when they had first started work at the home. Staff confirmed that they received regular supervision and appraisals.

Two people living at the service were accommodated in a bungalow in the main house's grounds. The bungalow looked very shabby inside, some double glazed windows were misting and it was in need of redecoration. The registered provider's representative walked around the outside of the building and came inside the bungalow with us and agreed with our comments. They said they would add the improvements needed to the action plan for the service.

We saw that the main house was clean and comfortable with no unpleasant smells. Some improvements had been made to the environment. For example, new flooring had been fitted to the dining room. The registered provider had produced a plan to deal with environmental issues. We saw a list of priority room refurbishments that indicated where redecorations were needed. There was also a schedule of works that had been agreed to start in February 2015 including repairs to the outside of the building.

Some people living at the service had dementia. The registered provider had given thought to helping people with dementia orientate themselves to time and place. For example, there was signage around the home indicating where toilets and bathrooms were located. There was also a board in the hallway displaying the date. However, we saw that the carpet throughout the home was patterned and wallpaper was flowery. Current good practice on dementia friendly environments suggests that too much pattern can over stimulate people's senses and increase stress.

People's capacity to make decisions for themselves had not been assessed. We saw the registered manager had begun the process, but that more detail was needed about the specific decision that needed to be made on each occasion. Although there was some evidence that family had been involved in planning people's care there was no formal process in place. This meant people may be at risk of not having their needs met in their best interests in line with the Mental Capacity Act 2005.

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 provides a statutory framework for acting and making decisions on behalf of people who lack the mental capacity to do so for themselves. It introduced a number of laws to protect these individuals and ensure that they are given every chance to make decisions for themselves. The deprivation of liberty safeguards provide legal protection for people who are, or may become, deprived of their liberty in a care home. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable, in a person's own best interests.

People were restricted from leaving the service by a key pad fitted to the front door. Whilst this was intended to prevent people leaving the service and being at risk it was also a form of restraint. There have been recent changes to

Requires Improvement

Is the service effective?

the interpretation to the deprivation of liberty safeguards and applications may need to be made on behalf of people who do not have capacity to consent to living in a service where the doors are kept locked. The registered manager was unaware of the new rulings on these safeguards and that applications may be needed for everyone living at the home. Following our inspections the registered manager told us they were making the relevant applications.

People told us that staff always asked if they wanted their personal care needs attended to. People were asked for their consent before staff provided personal care. Staff told us that if people refused verbally or showed physical signs they did not want to receive personal care, they would leave the person then go back and offer the care at a later time.

People were supported to maintain a healthy balanced diet. People told us they always got a choice of something else to eat if they didn't want what was on the menu. We spoke to the cook on duty who told us about how they knew people's food preferences. For example, we saw each person had a card that highlighted their preferences and any special dietary requirements, such as low sugar diets. People were offered drinks and snacks throughout the day. Where necessary food and fluid charts were used to ensure people had sufficient food and fluid intake. Staff had identified that one person had been losing weight and we saw that a plan had been put in place and the person's weight had increased.

People told us that if they requested a visit from their GP the staff would organise it. People's care plans showed evidence that their health care needs were met by a range of health care professionals including District Nurses and chiropodists.

Good

Is the service caring?

Our findings

One person told us staff were “always very amenable”. Always treated them with respect and were always kind to them. Another person said all staff were “very nice” and they “can’t fault any of them”. People told us they thought staff were very caring and respectful towards them.

One person told us they liked living at the service, because “no-one interferes with me I do what I like - can lie in if I want”.

Staff we spoke with were knowledgeable about people’s needs and told us what they did to meet people’s needs. For example, a staff member described how they distracted one person if they saw they were beginning to get distressed.

Another staff member told us they were able to communicate with one person in their native language (not English) and that this helped the person settle if they became agitated.

During our inspection all the interactions we saw between people living at the service and staff were positive and caring. Staff recognised when people could not verbalise their needs, and quickly responded to them. For example, when people became restless in their seat they were discreetly asked if they needed the toilet. Staff noticed that one person was not wearing their watch as they usually did. The staff member went to find the watch, ensured it showed the correct time and put it on the person’s wrist. We also observed one person displaying repetitive behaviour, staff identified what it was the person wanted and was able to meet their needs.

Throughout the inspection there was appropriate friendly banter between staff and people living at the service, with staff occasionally sitting and chatting to people.

We saw staff moving a person from an armchair to a wheelchair using effective techniques. They constantly reassured the person, telling them what was happening and thanking them for their co-operation with the transfer.

People told us that staff always asked them what they wanted or needed. We heard choices being offered all day such as what people wanted to eat or drink or where they wanted to sit.

Following our inspection we spoke with two health and social care professionals. Both told us they had no concerns about the care provided by the home and that staff were seen to be caring and polite on their visits.

Requires Improvement

Is the service responsive?

Our findings

We found that improvements were needed to the way in which complaints were managed, and how the information about people was obtained and held.

We saw that a list of complaints received was kept, but there was no evidence that they had been dealt with. One relative told us they were always raising issues with the registered manager, who did their best, but that sometimes issues were beyond their control. People told us that they knew how to make a complaint and who to raise a concern with. Whilst most people felt their concerns would be dealt with, one person said they had raised one concern on several occasions and it had not been dealt with.

Information about people was not always accurate and was sometimes confusing which did not help staff to respond to people in personal manner. For example, in one person's file we saw that their forename had been spelt three different ways. We also saw that one person had information on their file saying there was written information for them on the front door about how to open it, but also information saying this person could not read.

There was little evidence that people or their representatives had been involved in making decisions about their care. People's care plans did not always reflect how they would like to receive their care. There was some information about people's social history, where they had been born and whether they had been married. This information was limited and meant staff may not always have the information that would enable them to respond to the person in a manner the person would wish. Despite the lack of recorded information we saw that staff responded to people in an individualised manner and provided opportunities for people to talk with them. We saw staff engage in some spontaneous activities such as painting some ladies' fingernails. One person indicated to staff that they wished to blow bubbles. Staff fetched a pot of liquid and they and the person spent some time happily blowing bubbles. One staff member told us about one person's previous occupation and that by understanding what it was, they were able to provide similar activities for them to engage in.

People were supported to follow their interests and take part in social activities. For example, we saw that a person who liked gardening had been enabled to participate in some gardening related activities. People told us there were often planned activities on offer. They told us that they enjoyed the musical entertainments and the visiting animals.

One visitor told us that when their relative first lived at the service there was a "lovely, homely" feel to the service, but that the feeling had changed. They felt their relative did not have their social needs met, and that because they were quite independent with their physical needs, staff tended to leave them on their own. We discussed this matter with the registered manager and registered provider. We were told that local authority funding levels did not provide for meeting social needs. However, they aimed to provide as much social activity and interaction as possible.

People received care that was personal to them. For example, one person had been assessed by a psychiatrist as displaying behaviour that could be unpredictable. In order to minimise the person's distress staff continually reassured the person. We also saw that where one person was refusing to take their prescribed medicine, their GP had been contacted and alternatives were being discussed.

We saw that daily notes completed by care staff were general and task orientated. A common recording was 'all morning care given'. There was little recorded evidence that the specific care needs identified in the care plans had been met. However, everyone we saw looked well cared for and we saw no evidence that their needs had not been met.

People were able to choose who provided care to them. For example, we saw on the staff rota that some nights there was only a male carer awake. The registered manager told us everyone had been asked about this. They said that one person had told them they did not want to receive personal care from a male. This person did not require assistance with their personal care, but it had been agreed that if they needed help the sleep in staff (who would always be female) would be called.

Requires Improvement

Is the service well-led?

Our findings

We saw no evidence that people and staff were involved in developing the service. There was no evidence that people's views had been sought on the quality of care being provided or that the concerns people raised had been acted on. We also found that improvements were needed in relation to maintaining confidentiality and dignity.

People's dignity and confidentiality had not been considered. When we walked around the service, we saw that directions for staff on people's care needs were displayed on the wall in their rooms and packs of incontinence pads were also on display in people's rooms.

We saw some evidence, mainly signatures, that people had been involved in completing their care plans. Two visitors told us they had been involved in reviewing their relative's care plan. However, there was no other evidence that people were regularly asked for their views about the care being provided by the service.

Accident and incident records were found in different places within the files. Although all accidents and incidents were recorded they had not been analysed to look for patterns that could be used to minimise risks. The registered manager told us that they did not carry out any audits themselves. All audits were completed by the registered provider's representative who visited the home on a regular basis. For example, information on urine infections, risks of malnutrition and any medication errors was sent to the head office and analysed. Plans were then put in place by the service to minimise any identified risks. However, this was a new system that had not been used long enough to determine if it was to be effective.

Care files were not always well organised. We saw issues with care plans that had not been identified by the reviews that had been undertaken. Information was not easy to find and some of the information was confusing. For example, on one person's file we saw that their forename had been spelt three different ways. We also saw that one person had information on their file saying there was written information for them on the front door about how to open it, but also information saying this person could not read.

There was no evidence that the registered provider or registered manger had used CQC's new methods of assessing care to determine if the service needed any improvements. However, the provider had produced a document that looked at each of the 16 Essential Standards (standards previously used by CQC to determine if a service was compliant) and identified whether the provider was compliant with that standard. They had identified minor issues relating to information to be kept in each bedroom and medicine administration and had plans to address the issues.

There was no evidence that the registered manager had dealt with the concerns people had raised with them.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that they felt well supported by the registered provider and their representatives and could contact them at any time for advice. The registered manager had been at the home for just over a year and told us that they had built effective relationships with families and visiting professionals. They had increased staff training and social activities and improved staff morale. They had recently completed some training in dementia care with a renowned specialist in the field of dementia care and planned to use this to improve the care for people with dementia living at the service.

It was clear people knew who the registered manager was, people greeted them in a warm and positive manner. Staff told us that the registered manager was always available and that they 'led by example', showing them how good care should be delivered. Staff were clear about the values of the service. They told us the main value of the hservice was that it is the 'residents' home' and they should be able to ask for anything and feel comfortable and happy living there.

Staff told us they felt supported by the registered manager and that they would deal with any concerns. However, one person living at the home said they felt they were 'fobbed off' when they complained about missing clothes. Another person living at the home told us they would talk to the registered manager if they had any concerns about 'little things" and felt they would be "sorted".

Requires Improvement

Is the service well-led?

Prior to this inspection we had written to the registered provider asking them to look into concerns that had been raised with us. They responded promptly and satisfactorily, telling us about their investigation and what they had done to deal with the concerns.

One social care professional that we spoke with told us the registered manager had always been very helpful when they had visited the service. They also told us the registered manager was “very thorough” when assessing a person to see if their needs could be met by the service and that they felt “confident in placing people at Lake View”.

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	Regulation 11 HSCA (RA) Regulations 2014 Need for consent South West Care Homes Limited had not protected people against the risk of receiving care and treatment without proper consent because it had not assessed people's capacity. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance South West Care Homes Limited had not protected people against the risk of there being no system in place to regularly assess and monitor the quality of care provided. Regulation 17.