Alpha Health Care Limited

Lakeview Care Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 17June 2015 and was unannounced.

Lakeview has six units spread across the ground and first floors. The home offers care and nursing care, dementia care, and care for behaviours that challenge. The home can accommodate 151 people.

A manager was in post who was in the process of applying to become registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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.

People's risks were assessed in a way that kept them safe from the risk of harm but these did not always reflect people's current needs. There was not always enough staff around to ensure that people were supervised and/or that people's needs were met.

Summary of findings

Medication systems were in place to ensure that people received their medication safely. Some staff were unfamiliar with the computerised medication recording system.

People felt there was not always enough staff around who knew how to meet their needs. The provider was in the process of recruiting more staff to work at the home.

A staff training programme was in place to ensure that staff were trained to carry out their role and the provider had plans in place for updates and refresher training.

Staff were aware of their role in safeguarding procedures and told us they would report poor practice. Staff received training to ensure they could meet people's needs including training in how to keep people safe.

The Mental Capacity Act 2005 and the DoLS set out the requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. Not everyone who needed a mental capacity assessment had got this in place and staffs knowledge around MCA and DoLS was variable. This meant that decisions had been made for some people without gaining appropriate consent.

People were supported with their nutritional needs but it was not always clear if people had received enough to drink. Where people had significant weight loss referrals to healthcare professionals were not always made in a timely way.

People's health care needs were monitored and where people were at risk of developing pressure ulcers there was a plan in place to minimise the risk. However where people were receiving treatment for pressure ulcers these had not always been consistently followed by nurses.

On Kendal and Keswick unit's staff understood people's needs. Care was delivered with a person centred approach. On another unit care was delivered in a more task driven way and people did not always receive care and support at the time and in the way they preferred it.

Some staff displayed a more caring and interactive approach with people than others. People's dignity was not always promoted but people's privacy was upheld and people were treated with respect.

There was an activities programme in place but people had limited opportunities to be involved in hobbies and interests that were important to them.

The provider had a complaints procedure available for people who used the service and complaints were appropriately managed. People who used the service and their families felt able to raise any concerns they might have with the manager or other staff members.

Not all staff felt that the atmosphere of the home was open and inclusive. Some staff felt that they were not always listened to. Where there was a unit manager in place (Kendal and Keswick) the unit ran more smoothly and people received more consistent care and support.

The registered manager had systems in place to monitor the service but this was not always effective in bringing about improvements. Recent user surveys highlighted a need for improvements in several areas. The manager and operations director were developing an action plan for this.

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 consistently safe.

There were risk assessments in place to ensure people's safety but not always enough staff around to support people.

People were protected by the provider's staff recruitment process and staff knew how to raise concerns about poor practice and abuse.

Medicines were managed so that people received them safely.

Requires Improvement

Is the service effective?
The service was not consistently effective.

Staff received training they needed to meet the needs of those in their care but people felt there was not always enough staff around who knew their needs.

People's ability to consent had not always been assessed before staff supported them and decisions in people's best interest were not always made in line with the MCA

People requiring assistance at mealtimes were not always supported to have sufficient amounts of food and drink.

Requires Improvement

Is the service caring?
The service was not consistently caring.

Not all staff interacted well with people they were caring for and people's dignity wasn't always upheld. People's privacy was promoted.

People were enabled to express their views and be involved in making decisions about their care.

Requires Improvement

Is the service responsive?
The service was not consistently responsive.

Staff did not always respond to people's needs in a timely way and some people did not receive the right care at the right time and in the way they wanted it.

People were not routinely supported to follow their hobbies and interests and felt there was not much to do in the home.

People were able to raise concerns and/or complaints and knew that they would be taken seriously.

Requires Improvement

Is the service well-led?
The service was not consistently well led

Requires Improvement

Summary of findings

Not all staff felt that they received adequate support. Staff had mixed feelings about how they were supported and listed to. Staff felt more supported where there was a unit manager.

People who used the service received more consistent care and support where there was a unit manager in place.

There was a quality monitoring system in place which gave people and their families the opportunity to make suggestions for improvement. This had not always been effective in bringing about improvements.

Lakeview Care Home

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 17 June 2015 and was unannounced.

The inspection team consisted of four inspectors, two new inspectors and an expert by experience.

The provider had kept us updated of events by sending us relevant notifications. Notifications are reports of accidents, incidents and deaths of service users. The provider had also notified us of safeguarding incidents, these are raised when it is considered people maybe at risk of abuse.

We spoke with 28 people who used the service and 12 relatives. We spoke with the registered manager of the home, the deputy manager, 21 care staff, and the person responsible for activities. We also spoke with the operations manager.

We observed the care and support people received in the home. This included looking in detail at people who used the service and whether the care and support they received matched that contained in their care plans. This is called case tracking. We also looked at these people's daily care records and records of their medication. We spoke with staff about how they met the needs of these people and others.

We carried out a Short Observational Framework Inspection (SOFI) as part of our inspection. This is we spend time in a communal area to observe how people who use the service receive care and support and how staff interact with people.

We looked at records relating to the management of the service. These included audits, health and safety checks, staff files, staff rotas, incident, accident and complaints records and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

Risks to individuals were not always managed appropriately on all of the units. On one unit we saw good examples of how staff supported people to keep them safe. However, on another we saw people were not always supervised appropriately. For example staff told us that two people were at risk of falls and required,"constant supervision." A staff member said, "Two people walk around a lot and there must be a member of staff at all times in the communal lounge due to the high risk of falls." We observed through SOFI, and general observations, that there were periods of time where there was not a member of staff present to supervise the people and keep them from falling.

People who used the service and staff thought that there was sometimes not enough staff provided to meet people's needs. A person said, "There are never enough staff around and certainly not enough permanent staff. A staff member said, "The dependency of people is so high and it often takes all morning to get people up, washed and give them breakfast." We saw that staff were still helping people to get up and have breakfast late into the morning.

We had received concerns that some people may be being nursed in bed rather than enabled to sit out. We saw that a person with dementia care needs was sat out of bed when their relative was with them. They walked with assistance and took their meals sitting in a chair. However, when the relative was not visiting, the person remained in bed with bedrails in place. The relative said, "[person's name] could sit out all day if there was enough staff to check on them, but they have to stay in bed when we are not here as there are not enough staff on duty." The provider told us, and we saw, that they were reviewing staffing levels across the home in order to ensure there was enough staff provided to meet people's needs. There was a recruitment drive in place to help recruit more permanent staff to work at the home.

We had received concerns that people may not be receiving consistent treatment of pressure ulcers. We found that records did not always support staff to deliver the correct treatment. Records identified that instructions for dressing changes had not been consistently followed by staff. The provider carried out audits of pressure ulcers but this did not identify whether treatment plans had been followed and/or if treatment had been effective.

Discussions with the provider identified that they would be developing their audit tool to ensure that this included looking at pressure ulcer treatment plans. We saw that people who were at risk of developing pressure ulcers were provided with the relevant pressure relieving equipment. We also saw that, whilst people were nursed in bed staff assisted them to change their position to help avoid skin damage.

People who used the service were kept safe because there were systems in place to report abuse and staff knew how to recognise and report poor practice and/or abuse. A staff member told us, "I would go straight to the nurse in charge or the deputy or the manager." Staff told us that they received training in safeguarding adults and we saw this recorded. We received appropriate notification from the manager and staff at the home each time they referred a safeguarding to the local authority. We had received a high number of safeguarding referrals from some of the units in the home. Staff explained that these were mainly in relation to people with behaviours that challenged and altercations between people. The provider had managed some of the safeguarding concerns by changing one unit into two (Kendal and Keswick), one male and one female.

We saw that people were kept safe because staff were carefully selected to work at the home. A staff member told us that they had had to provide information including past history of employment, two referees, identification and proof of eligibility to work in the country. Staff recruitment records we looked at identified that references had been obtained and relevant checks had been carried out including criminal records checks to ensure that staff were suitable to work in nursing homes.

We saw that medicines were managed so that people received them safely. We observed staff administering medication to people at the time and in the way they preferred. However there was some confusion about whether or not a person had received their medication during the previous night as this was not signed for on the computerised recording system. The person was very agitated for long periods of time. We saw that the staff managed the situation well, resulting in the GP prescribing another medicine for the person. The person then became much calmer. The provider told us that only staff who are familiar with the medication recording system would be allowed to administer medication to people.

Requires Improvement

Is the service effective?

Our findings

Staff told us that they received the appropriate training to meet the needs of people and records identified that staff had received training. We saw how staff responded to people who displayed challenging behaviour. For example we saw staff responding by talking calmly to a person, holding their hand and leading the person away into a quiet area and the person became calmer. We observed staff successfully using these techniques for a person on a few occasions. The person became calmer each time staff did this. We observed staff using manual handling equipment safely to move and handle people and staff told us they had received training for this. Not all staff were aware of the Mental Capacity Act and Deprivation of Liberty Safeguarding. The provider had identified this and told us that all nursing and care staff were receiving MCA and DoLS training so that there would be a greater staff awareness and understanding of people's needs in relation to this.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA and the DoLS set out the requirements that ensure where applicable, decisions are made in people's best interests when they are unable to do this for themselves. We saw that this process had been followed for some people but not for others. There were people who staff told, and we saw, did not have the capacity to consent and there were mental capacity assessments in place for these people. Best interest decisions had been made following meetings and discussions involving relevant people. However, for other people who did not have capacity to consent mental capacity assessments were not in place. This meant that for some people decisions were made about their care and support needs without assessing their ability to consent. An example of this was that some people had bedrails in place and mental capacity assessments and consent for the use of bedrails had not always been obtained. We spoke with the manager about this as the use of bedrails without gaining consent could be viewed on as restraint.

This is a breach of Regulation 11 HSCA (RA) Regulations 2014 Need for consent

A Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) is a legal order which tells a medical team not to perform CPR on a person. Where the person is unable to make a decision about this, following a MCA their family or representative should be involved in the decision making. We saw that reviews of DNACPRs did not always include discussions with family members or representatives. A relative who was visiting confirmed that they had not been involved in the recent review of their relative's DNACPR. These concerns about the GP practice had already been discussed during a recent safeguarding discussion.

People were not always supported to have sufficient to eat and drink. People who required help to eat their meals did not always receive help in a timely way. For example we observed that one person's hot meal was placed in front of them and staff did not return for 30 minutes and the meal went cold. People who were at risk of dehydration were not always supported to drink enough and records around fluid intake were not always accurate meaning that people remained at risk of dehydration. For example we saw that staff poured a cup of tea for a person and another person went over and drank this. However on the fluid intake chart it was documented that the person had consumed this.

People were not always supported to maintain good health. When people lost weight, or were at risk of malnutrition there had not always been a timely referral to the GP or dietician. An example of this was where a person had lost four kilos in two weeks. A referral had not been made to the GP. For another person, where records indicated poor fluid intake, we could not see where action had been taken to report/refer this.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity. We observed two people who had stained clothing being left in the same clothing throughout the afternoon, even though staff had attended to them and their toilet needs. We noted that care was not always delivered in a person centred way. We saw staff going from room to room and ticking off on their list when each task (such as re-positioning and giving a drink to the person) had been done. Staff were not always referring to people's preferences in relation to their wishes around how they wanted their care and support delivered.

People who used the service told us that they did not always receive care in the way they wanted. One person said, "The permanent staff are fine they know how I like things done but there are too many agency staff and you have to keep explaining to each one." This meant that people may not always receive the care they wanted at the time they wanted it. The provider was reviewing how people receive care with dignity and had introduced dignity training for staff. We noted that five staff members were dignity champions in the home. This meant that they could offer support and advice to other staff about how to promote dignity for people who used the service.

We saw that some staff related and communicated with people better than others. We observed during lunchtime two staff members helping the same person to eat their meal. One staff member was much more communicative with the person than the other and the person responded much better for the first staff member than the next one who came to feed them. We saw good examples of staff displaying a caring attitude towards people. For example we saw a staff member using physical contact to calm a person and this worked really well for the person. The staff member told us that they always treated people as if they were their own family.

Privacy for people was promoted by staff. Personal care was carried out discreetly in bedrooms and bathrooms. People were visited by health care professionals in the privacy of their own bedrooms.

People were involved to some degree in making decisions about their care. A person said, "The girls always ask me what I would like to wear, if I would like to stay in my room or go to the lounge, things like that. But some things you have to just go along with because they are so busy." Relatives told us they were kept informed of changes and felt that they were informed and involved in their relative's care.

There was an open visiting policy and relatives could visit at any reasonable time. One person said, "I visit at different times because I work shifts and there is never any problem with me visiting".

Requires Improvement

Is the service responsive?

Our findings

People told us that there was not much in the way of activities and entertainment in the home. We saw that some units provided more social engagement for people than others. From our observations, people who used the service were either in bed for most of the day or sitting in their rooms or communal areas with little social interaction. A person told us, "It's very boring there isn't much to do here." Another person said, "There's nothing much to do here, just watch the world go by." During a period of SOFI, we saw that no one was supported to be engaged in any social or occupational activity. People were left unsupervised with very little staff interaction for long periods of time. A staff member said, "There is nothing much for anyone to do really" and "We don't have time for anything other than providing basic care." On Kendal and Keswick units people were encouraged to participate in activities, hobbies and interests. Staff were observed interacting with people in a positive way on a one to one basis which encouraged the person to remain calm and focussed. There was an enclosed garden area where people could wander around and explore. There was a car (not drivable) which had been brought into the garden so that people who were interested could go and sit in and explore. We were told that there was a couple of people who particularly enjoyed the car. There were also chickens wandering around for people to watch and pet.

Some staff were more responsive to people's needs than others. We spoke with staff who were able to describe people's individual needs. An example was where a staff member explained how a person could become distressed and responded to physical touching. We later observed the staff member stroking the person's hand and face. They had also put the music on for the person which they liked and we saw the person smile when they did this. However we saw another staff member who did not converse at all with a person whilst helping them to eat their lunch. People told us that some staff were more responsive to their needs then others.

Some people were aware that they had a care plan in place and other people were either unaware or unable to answer. Relatives said that they didn't routinely get involved with care plan reviews but could discuss care and support needs with staff members if they wanted to. People who used the service and their relatives were usually kept informed of any changes to their care and support needs.

There was a complaints procedure in place and people told us that they felt able to raise concerns with staff and the manager. However people felt that because there was a lot of agency staff on duty, permanent staff were not always available to talk to. A person said, "You have a job to get to talk to a staff member who knows you because there are such a lot of agency staff." People could be confident that formal complaints would be addressed. We saw that the manager and operations manager responded to formal complaints according to the complaints procedure. This included investigations being undertaken and people receiving written responses to their complaints.

Requires Improvement

Is the service well-led?

Our findings

Where there was a unit manager in place (Kendal/Keswick) it was evident that people were receiving more person centred care and support. There was more guidance and support for staff on these units and there was a clear approach as to how care should be delivered. People and/or their relatives were involved in the assessment and delivery of care. Staff on this unit felt supported in their role. Staff on other units in the home where there was no manager said that they felt supported by the registered manager and deputy manager but thought that more day to day management was needed to support them in their role. A staff member said, "It will be better when we get a manager on the unit, it's a bit chaotic at the moment." The provider was in the process of recruiting managers for all of the units in the home.

Staff had mixed feelings about the way they were supported. Some staff said that they felt able to approach the registered manager and that they would listen and support them. Other staff felt that they were not listened to or supported and some staff felt that their suggestions were not considered. All staff we spoke with were aware of the Whistleblowing procedure and told us that they felt able to raise any concerns about poor practice and knew that the manager would support them with this.

Staff received regular formal supervision which helped to ensure that staff were supported in their role. Supervision is where a staff member meets usually with their line manager to discuss their progress, performance, experiences, training needs and plans and any concerns they may have.

There was a quality monitoring system in place. This had picked up some areas for improvement but not others. For example, we could see improvements had been made as a result of care plan and medication audits. However, the audits relating to pressure sores had not been effective in identifying inconsistencies in pressure ulcer treatment. Clinical Governance meetings took place monthly where the managers discussed the results of audits, incidents and accidents. We saw the minutes of these meetings where action had been identified to bring about improvements in relation to the accident analysis.

People who used the service and/or their relatives were encouraged to express their views and make suggestions for improvement. We saw that the provider had sent out user surveys in January 2015. We saw that the provider had analysed the results of the survey and that most people were happy with the services they received. Where people had concerns or suggestions for improvement the provider had highlighted this and action plans had been put into place to help bring about improvements.

The manager was aware of their responsibilities in relation their CQC registration. We had received relevant notifications in relation to safeguarding referrals and other significant events from the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider was not adhering to the Mental Capacity Act 2005 in respect of gaining consent from people.**