LVNH Limited

Lakeside View Nursing Home

Inspection report

68-69A Promenade
Southport
Merseyside
PR9 0JB

Date of inspection visit:
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24 January 2017
25 January 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 23, 24 & 25 January 2017. The service was last inspected June 2015 and rated as 'good'. A comprehensive inspection was carried out in January 2017 as there has been a change of legal entity for the service.

Lakeside View is a care home located in a residential area of Southport, near to the town centre. The aim of the service is to provide nursing care for people who are living with dementia and enduring mental health needs. All floors are accessed by a passenger lift and on the mezzanine level there is a stair lift. There is car parking space to the front of the home and a terraced garden.

The service had a newly appointed registered manager in post. 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 HSCA and associated regulations about how the service is run.

When looking round the home we saw there were some adaptions to promote an environment suitable for people with dementia.

We recommend however that further consideration needs to be given to further developing the environment in accordance with 'best dementia practice' to support people's physical/ emotional wellbeing and promote their independence.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 (MCA) were followed, in that an assessment of the person's mental capacity was made and decisions made in the person's best interest.

The registered manager had made appropriate referrals to the local authority applying for authorisations to support people who may be deprived of their liberty under the Deprivation of Liberty Safeguards (DoLS). DoLS is part of the MCA and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. Applications were monitored by the registered manager.

The staff we spoke with described how they would recognise abuse. Staff received safeguarding training and understood their responsibilities to report any concerns.

Staff were recruited safely, with appropriate background checks to ensure people who were barred from working with vulnerable people were not employed.

Staff were present in sufficient numbers to enable people's care and support to be provided in a timely manner. Appropriate intervention was provided by the staff when people needed support. Changes were,

however being made regarding the deployment of staff to ensure more staff were available in the lounges/dining room as key times.

People had a plan of care which recorded their care and support needs. Care was organised so any risks were assessed and plans put in place to maximise people's independence whilst minimising risks to their safety.

We saw relative involvement with the plan of care and care documents were kept up to date through regular care reviews.

Appropriate referrals were made to external health professionals for advice and support to ensure people's health and wellbeing.

There were systems in place to make sure medicines were given safely in the home. Management undertook checks of records to ensure medicines were managed safely.

A varied programme of social activities was offered to people living at the home based on individual need and preference. This helped to promote people's social independence.

Staff received an induction and worked with more experienced staff. Staff received training and support to ensure they had the skills and knowledge to undertake their job role effectively.

Staff were polite, patient and caring in their approach. Staff had a good knowledge of people's care needs and how they wished to be supported.

People's nutritional needs were managed in accordance with their dietary requirements. People were offered a good choice of hot and cold meals and drinks.

Risks within the environment were assessed to help maintain a safe environment for people to live in.

We found the home clean on our inspection though following our visit concerns were raised regarding some cleanliness issues and the provider will be providing a written response.

A complaints procedure was in place and relatives we spoke with were aware of how they could complain. We saw that a record was made of any complaints and these had been responded to.

Quality assurance systems and processes were in place to help assure the service. This included a number of audits and also obtaining feedback from people who used the service and their relatives. This was obtained via daily discussions, meetings and surveys. We saw some actions were taken to improve practice and to drive forward improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

We found systems in place to ensure medicines were managed safely.

Staff had been thoroughly checked when they were recruited to ensure they were suitable to work with vulnerable adults.

There were enough staff on duty to help ensure people's care needs were met though changes were being made to the deployment of staff for the communal areas at key times of the day.

Risks associated with people's health and risks associated with the environment were monitored to help keep people safe.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

We found the home to be clean on inspection though some concerns were raised following the inspection around the standard of cleanliness which the registered manager was addressing.

Is the service effective?

Requires Improvement

The service was not wholly effective.

Further development was needed around the provision of a dementia friendly environment to support people's physical/ emotional wellbeing and promote their independence.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed.

Staff were suitably trained and supported to ensure that they could meet the needs of the people living at the service.

People's dietary requirements were assessed and there was a

good choice of food available.

People had access to external health professionals to help monitor their health and wellbeing.

Is the service caring?

Good

The service was caring.

Relatives said the staff were caring and provided good support.

When interacting with people staff were respectful and displayed a caring and patient nature.

People and relatives were involved with the plan of care and decisions made.

Is the service responsive?

Good

The service was responsive.

People were encouraged to take part in a varied social programme taking into account people's preferred interests.

Care was planned with regard to people's individual preferences.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain. Complaints made had been addressed.

Is the service well-led?

Good

The service was well-led.

There was a registered manager working at the home.

There were a series of on-going audits, quality checks and feedback sought from people/relatives to ensure standards were being maintained and to further develop the service.

Staff were motivated to do their jobs and enjoyed working at the service.

The Care Quality Commission had been notified of reportable incidents in the home.

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

This was an unannounced inspection which took place on 23, 24 and 25 January 2017. The inspection was undertaken by two adult social care inspectors 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.

During the visit we were able to meet and speak with three people who were living at the home and 10 visitors/relatives. We spoke with 10 of the staff working at Lakeside View including two nurses, two care staff, a domestic member of staff, chef, two activities co-ordinators, deputy manager, registered manager and a provider. We also spoke with two health professionals who had contact with the home. We looked at the care records for seven of the people staying at the home as well as medication records, six staff recruitment files and other records relevant to the quality monitoring of the service. These included safety and quality audits including feedback from people living at the home.

During the inspection we observed care by carrying out a SOFI observation. SOFI stands for Short Observational Framework for Inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We undertook general observations and looked round the home, including people's bedrooms, bathrooms, the sensory room and the dining/lounge areas.

Good

Is the service safe?

Our findings

During our inspection we used a number of different methods to help us understand the experiences of people who lived at Lakeside View. This was because the people who lived at the home were not always able to communicate their needs and we were not always able to directly ask them their views or experiences about the home. We asked relatives if they thought the home provided a safe place to live and if staff provided care in a safe way. Relatives we spoke with confirmed this. A relative told us that that when they left the home they knew their family member was well cared for and they did not have to worry. Relative comments included, "Exceptionally safe, couldn't ask for better", "Yes we feel safe because the staff always call and let us know how (person) is", "Yes, it's safe because you see the same staff", "There are always staff around when you need them", and "They (staff) especially (staff member); always let me know what is going on." A person who was living at the home said, "I like it here".

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to the management team. This included notifying the local authority in accordance with the agreed protocol to ensure the safety of vulnerable people. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. In respect of reporting allegations of abuse to the local authority we saw evidence of the referrals being made by the service appropriately and in a timely manner. For one alleged incident the service had however not notified the local authority. The registered manager and provider were able to provide details of actions taken at the time of the incident to ensure the person's safety. We discussed with the registered manager and provider reporting procedures to the local authority where an allegation of abuse occurs. The registered manager has since reviewed their reporting procedures, notified the local authority and the Care Quality Commission (CQC) of the alleged incident (in accordance with our regulations). Following the inspection we received some safeguarding matters where concerns had been raised. The overall review of these matters had not been concluded at the time of our visit and therefore we are unable to comment on the findings in this report. The provider has been asked to provide a written response in respect of concerns around the control of infection in the home.

We saw staff received regular safeguarding training and contact details for reporting an alleged incident to the local authority were displayed. Staff members said that they would go to the line manager to report abuse. One staff member said, "I would speak up immediately if something was wrong."

People living at the home appeared very relaxed and comfortable with the staff when they were supported by them. The service had a system of securing areas in corridors, lifts, staircases with keypad operated locking systems in order to protect the vulnerable people living at the home.

We checked to see if there was sufficient staff to carry out care in a timely and effective manner. There were 42 people living in the home at the time of our inspection. On the first day of the inspection the registered manager was on duty with a trained nurse, seven care staff and three care staff supporting people on a 'one to one' (staff member stays with an individual at all times to keep them safe and attend to their needs). There were two domestic staff on duty, along with a laundry assistant, chef, kitchen assistant, chef on

induction, administrator and an activities organiser. There should have been two trained nurses on duty each day however due to unforeseen circumstances (of the week of the inspection) this cover had not been possible.

The deputy manager was able to provide examples of the staff working flexibly. For example, during the inspection the deputy manager and registered manager [both nurses] came in early to support the nurse on duty as they were 'one nurse down'. We also saw that in respect of organising the shifts, the morning shift had been changed to start at 8am rather than 7am to meet the current needs of the people they were supporting. One staff member still however came in at 7am to help the night staff.

Staff told us there were good staffing levels, and that agency staff are used when necessary. We saw that agency staff were used to fill 'gaps' in the off duty if they could not be covered by the home's staff. The same agency staff attended the home where possible to help ensure staff continuity.

Throughout the day we saw staff checked up on people's safety ensuring their comfort and wellbeing. We observed people receiving support when they needed it, for example, during meal times, with daily tasks and aspects of personal care. People were able to move around the home freely with or without staff support. We did see that on occasions (mainly in the afternoons) the main lounge was left unattended. This however was for only very short periods of time and often due to staff supporting people who wished to walk to a different area of the home or who needed support with personal care. Following the inspection the registered manager informed us of the changes they were making in respect of staff resources and maximising the communal areas on both floors of the home to increase staff observations.

We reviewed six files relating to staff employed at the service. Staff records viewed demonstrated the registered manager had robust systems in place to ensure staff recruited were suitable for working with vulnerable people. The registered manager retained comprehensive records relating to each staff member. Full pre-employment checks were carried out prior to a member of staff commencing work. This included keeping a record of the interview process for each person and ensuring each person had two references on file prior to an individual commencing work.

The registered manager also requested a Disclosure and Barring Service (DBS) certificate for each member of staff prior to them commencing work. A valid DBS check is a check for all staff employed to care and support people within health and social care settings. This enables the registered manager to assess their suitability for working with vulnerable adults. This confirmed there were safe procedures in place to recruit new members of staff.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits, safety checks of equipment and service contracts were in place. Any potential hazards were identified and monitored for safety purposes and maintenance repairs were carried out in a timely manner. We spot checked safety certificates for electrical safety, gas safety clinical waste, the lift and for Legionella compliance. We also looked at a number of safety checks undertaken. For example, fire equipment, hot water, specialist mattresses and window restrictors. These checks were up to date.

A 'fire risk assessment' had been carried out and was updated regularly. Personal emergency evacuation plans (PEEP's) were available for the people resident in the home to help ensure effective evacuation of the home in case of an emergency, for example, a fire.

Last year there had been input from a local community health team to help improve the control of infection in the home. This was because an infection control outbreak had not been managed effectively. Following

this incident staff had received in depth training to improve infection control practices. We looked around the home and found the areas seen to be clean and hygienic. Staff had access gloves, aprons and cleansing hand gel. A relative told us there were on occasions some issues around the general cleanliness of the home though this was being monitored by the staff. Domestic cover in the home was adequate. There were two domestic staff on three days a week and three domestic staff four days a week. The domestic hours had been increased to make sure the cleanliness of the home was kept to a good standard. Domestic staff completed cleaning records and the chef informed us of the cleaning undertaken in the kitchen. We saw the cleaning record in the kitchen had not been completed since December 2016; a new cleaning record was implemented during the inspection. A person living at the home said, "They (staff) clean my room every morning, and my bedding is changed regularly."

We saw how accidents and incidents were monitored in the home. All accidents were recorded and reviewed by the registered manager for any emerging trends or patterns. The staff had put measures in place to help monitor people who were at risk of falls. As part of monitoring people's safety and in accordance with their assessed need, there were alarm mats, bed rails and bedrooms which had sensors connected to the doors to enable staff to be aware when people entered or left their room. This helped the staff to provide support in a timely manner and reduce the risk of a person falling.

The care records we looked at showed that a range of risk assessments had been completed to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and the use of bed rails. These assessments were reviewed each month to make sure appropriate measures were in place for people's safety and to maintain independence.

During this inspection, we looked to see if there were systems in place to ensure the proper and safe handling of medicines. We saw medicines were administered safely to people. A relative told us the staff were good at liaising with their family member's GP and the mental health team in respect of the medicines they were taking.

Nursing staff administered medicines to people. The nursing staff had attended medicine training to ensure they had the skills and knowledge to administer medicines safely to people.

We found medicines to be stored safely when not in use. Some medicines needed to be stored under certain conditions, such as in a medicine fridge, which ensures their quality is maintained. If not stored at the correct temperature they may not work correctly. The temperature of the drug fridge was recorded daily. This helped to ensure the medicines stored in this fridge were safe to use.

Staff were not administering controlled drugs at this time. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation. The majority of medicines were administered from a bio dose system (medicines dispensed in a sealed pack). We checked a sample of medicines in stock against the medication administration records and found these to be correct.

People had a plan of care which set out their support needs for their medicines. We checked six medicine administration records (MARs) and found staff had signed to say they had administered the medicines. We found records were clear and we were easily able to track whether people had been administered their medicines.

People's plan of care recorded PRN (as required) medicines to be given. We saw that regular contact was made by the staff with GPs in respect of reviewing medicines, including the use of PRN medicines. We talked with the deputy manager about implementing further guidance, for example, PRN protocols to help monitor

their use. The deputy manager said they would implement these to support this practice.

The majority of topical preparations, such as creams, were administered mainly by the care staff. Care staff signed cream charts following administration of creams and these were up to date. We discussed with the deputy manager the use of a body map which would show the areas of the body the cream needed to be applied to. The deputy manager said they would implement this to support this practice.

Requires Improvement

Is the service effective?

Our findings

Within the environment there was some reference for helping support people living with dementia. The home was well lit, corridors were kept clear from equipment and the floors had no raised edges to reduce the risk of trips and falls. Each floor of the home was a different theme, to help people recognise where they were. There was however a lack of signage for the bathrooms and no personalisation on each individual bedroom door which would be instantly recognisable to a person living with dementia. This along with contrasting colours would help to orientate people to their surroundings which would also provide assurance for them. There were some pictures on the walls however there was a lack of objects on the walls which would provide tactile stimulation. The home had a sensory room which had recently been located to another part of the home. A sensory room provides an area for enjoying different sensory experiences that can be stimulating or be calming. The registered manager said this was not in use and they were aware that the room, along with other areas in the home needed further development in respect of providing a more suitable environment for people with dementia.

We recommend the provider considers further development of the home's environment in accordance with 'best dementia practice' to support people's physical/ emotional wellbeing and promote their independence.

We asked relatives what they thought about the care and support their family member received. Relatives made the following comments, "I think the staff are skilled, they know what to look at for,", "They know their stuff", "I leave home at night and am not worried" and "I have no cause to complain, they are skilled". A health professional said, "I have never had any problems when I have asked them to follow specific instructions." Relatives told us they were informed if their family member became unwell and staff contacted the GP promptly if for example, 'someone is feeling poorly, or has a headache'.

We looked at the training matrix which showed that all staff had attended training in subjects such as first aid, safeguarding, medication, autism, and conflict. We saw that staff had training certificates which we checked. New starters completed an induction over the first twelve weeks of their role which was aligned with the principles of the Care Certificate. The Care Certificate is a set of standards health and social care workers can adhere to as part of their role. We saw that training was classroom based for mandatory courses such as first aid, manual handling and physical intervention. These were completed by qualified trainers. Each of these training sessions contained a practical session, and a competency assessment to check that the staff had understood the content of the courses.

We saw from looking at the service's training matrix that 'lakeside training' had been completed in areas such as health and safety, infection control, food hygiene and documentation, nutrition, dementia awareness and customer care. We saw that there were some gaps on the training matrix, however when we queried this, we were shown additional training dates that the staff were booked onto in the next few weeks. Once staff had completed their induction they were enrolled on Level 2 or 3 NVQ (National Vocational Qualification) in Health and Social care; staff who had worked at the home for this length of time had been enrolled on this qualification.

Supervisions were taking place every two months for existing staff, and every week for new starters. The registered manager told us, "I like to supervise new starters this often to ensure they have access to continuous support." We did not read the content of anyone's supervision, but saw examples of topics discussed. Supervisions were split into three areas, professional, training, and personal. Staff appraisals also took place. Staff we spoke with confirmed they received a good level of support and attended regular supervision meetings.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The DoLS provide a legal framework to protect people who need to be deprived of their liberty in their own best interests. We saw staff were receiving training around the MCA and DoLS.

We checked whether the service was working within the principles of the MCA by looking at three people's care plans who had a Deprivation of Liberty Safeguard in place and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that people's capacity was assessed for different aspects of their daily choices such as washing and dressing, nutrition, and continuous one to one supervision. Mental Capacity assessments contained a level detail including the rationale for why that person was deemed not have capacity for certain decisions.

We saw that the service was implementing a new system of accessing capacity, which included more family involvement and consultation, to show that were decisions were required to be made in people's best interests family were more involved in this process. For example, a person's family had LPA (lasting power of attorney for health and finances) and we saw they had been involved in any decision about the person's care and had signed their care plan.

We saw a well-documented and thought out decision around using medication covertly for one person in their 'best interest'. A mental capacity assessment had been undertaken along with holding a 'best interest' meeting involving relevant health professionals, staff and relatives to decide whether administering medicine covertly was in the person's best interests. A plan of care was in place to support this practice which was subject to regular review

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) plans were in place for some people. These were in accordance with the MCA and had been coordinated by the person's GP.

We observed staff providing support at key times and the interactions we observed showed how staff communicated and supported people and asked their consent to care. When we spoke with staff they were able to explain each person's care needs and how they communicated these needs.

People had a plan of care to identify care needs. A nursing care plan provides direction on the type of care an individual may need following their needs assessment. Care planning is important to ensure people get the care they need when they are at care home. Care plans covered areas such as, mobility, personal hygiene, falls prevention, diet and nutrition, privacy and dignity, constipation, personal care, sight, nutrition,

mobility, care of skin, falls, social care and medical conditions that require clinical intervention. For example, pressure ulcer, or tube for enteral feeding. Enteral feeding refers to the delivery of a nutritionally balanced feed via a percutaneous endoscopic gastrostomy tube (PEG). The PEG is passed into a patient's stomach to provide a means of feeding when their oral intake is not adequate.

We reviewed a plan of care for a person who had a PEG feed. The care requirements for the PEG tube were recorded on the person's plan of care. Staff told us they undertook this care each day to ensure the PEG tube was patent. This aspect of the person's care was not always recorded and the deputy manager amended the person' care chart to provide an accurate record.

Care records showed visits by health and social care professionals. These visits were requested when staff had concerns about a person's health or they required support with their healthcare needs. This included visits from GPs, dietician, swallowing and language therapy team (SALT), mental health team and psychiatrist. An external health care professional told us the staff made referrals at the appropriate time for advice and support.

Care staff completed care monitoring charts for different aspect of care. For example, diet and fluids and pressure area care. Two hourly night checks were also recorded by the staff to check on people' safety and to evidence the care they gave overnight and report on their sleep pattern.

The main meal of the day was served at lunch time. We saw that some people were sitting for more than fifteen minutes before they received their lunch which made some people restless in their chairs. The registered manager was aware that the timing around this needed to be reviewed to improve the dining experience for people. Sufficient numbers of staff were present to serve and support people with their meals in a timely manner. People told us they liked the food. Although unsure about the choice of meal people told us they could have something different if they did not like the menu choice.

There was a pictorial menu on the dining room wall which identified the meals of the day. People were offered a four week menu and meals were fortified with butter and full cream milk to promote a good calorie intake. Dining tables were not laid in advance though mats and condiments were provided as the food was served. Adapted crockery was available and plastic plates and glasses were being used to help support people with their meals.

We checked to see how the uses of fluid thickeners were managed for people who had difficulties swallowing, eating and drinking and therefore at risk of choking. There was little information recorded on medication records (MAR's) to advise staff of the consistency of fluids though staff were aware of the different fluid consistencies which had been prescribed for individuals by external professionals, for example, SALT team. We discussed with the deputy manager 'more accurate ways' or recording thickening agents. During the inspection the deputy manager made changes to the care documentation to improve the recording of thickening to ensure people's safety when eating and drinking.

Good

Is the service caring?

Our findings

During the inspection we asked relatives if they thought the staff were polite and caring in nature. Relatives said staff were polite, patient and care was given with respect, allowing people's dignity to be maintained. Their comments included, "Ten out of ten", "Wonderful staff", "Couldn't ask for better", "Smashing" and "They are all lovely". Relatives gave us examples of good practice. For example, if a family member had a toilet accident then staff would respond by saying "Oh I think you have spilled your drink, shall we go and get some dry clothes", or asking permission of the person before proceeding with any care.

Care plans we looked at were written in ways which demonstrated the provider's commitment to person centred care. Person centred care means care and support is provided in accordance with their individual needs and requirements, also taking into account their personal wishes. Care plans recorded good information to provide a full picture of each person for staff to support them. This included details about any sensory impairment, whether a person wore a hearing aid or glasses, their preferred time of getting up in the morning, retiring at night, sleep routine, meals they enjoyed and how they communicated. Non-verbal communication such as, gestures, facial expressions and tone of voice displayed through body language was assessed and recorded. Care documents recorded whether a person wished to receive support from male or female staff as a mark of respect.

A dignity champion was appointed in the home to oversee standards associated with dignity and respect. A dignity tea afternoon was arranged for people, relatives and staff to promote an awareness and understanding around privacy, dignity and promoting people's rights.

Talking with staff and through our observations we saw staff had a good understanding of the ways in which people wished to receive their care and support and how they communicated. We observed kind and caring interactions between staff and people who lived at the home. Staff clearly knew the people they supported well and positive relationships between staff and people they supported were evident. We observed two members of staff support someone to stand from their chair. The staff spoke softly to the person, and used the correct technique to help them stand. The person being supported looked relaxed with the staff. We heard staff asking permission from one person they were supporting to place an apron around them to protect their clothing; the staff member was very chatty and reassuring throughout the meal. Staff told us they would always knock on a person's door before entering. There were two occasions however when this practice was not followed. We brought this to the registered manager's attention during the inspection.

We observed one person, who was napping, being gently woken up by staff in order to give them their medications. The staff member was respectful in their approach and said, "Excuse me," and "Sorry to bother you." The staff member also told the person what the tablets were and why they took them.

Staff were aware of how to respect and follow people's choices and wishes for end of life care. Formal training in end of life care had been achieved by the staff at the home. We saw for a person who was approaching the end of life, care documents were in place which fully supported their individual needs and choices. The plan of care had been implemented in consultation with the family and a health care

professional who was involved with their care. This helped to ensure the person's needs were appropriately met in a dignified and sensitive manner.

Local advocacy service details were available and displayed for people to access. A person at the home was receiving support from an advocate at the time of our visit and this support was well documented.

A service user guide was available and this provided information about the home and the services it offered.

We saw relatives visiting during the inspection. Relatives told us they could visit at any time and were made welcome by the staff.

Good

Is the service responsive?

Our findings

Relatives we spoke with told us the staff knew their family member very well. They said the staff had a good understanding of their family member's likes and dislikes, how they wished to be supported and were prompt in picking up on any change in health or behaviour that may affect wellbeing. Relatives said any difficulties arising were always discussed with them and they were kept informed of any change with their family member's care. A person told us about choices they were offered in each day, for example, taking a shower or bath.

During the inspection the staff knew the schedule of the day and there was a calm friendly atmosphere. Staff received a handover at each shift change regarding people's needs and any change in care or treatment. Significant developments were also discussed and where a need had been identified for external advice from a health professional this had been sought. Dietetic support took place during the inspection for four people as staff had concerns around their intake.

We observed that when people requested assistance staff were prompt in responding. People were not left waiting for assistance which could increase their anxiety or affect their well-being.

When we talked about care planning relatives said they were involved in their family member's care reviews. A relative said, "I am always involved, all decisions are discussed with me." A care needs assessment had been completed and the information used to drawn up a plan of care. The plan of care reflected people's individual needs, preference and choices. This included social background and hobbies and interests people enjoyed before coming into the home. Care files recorded meetings held with relatives and other relevant health professionals to evidence their inclusion.

We spoke with the two activities co-ordinators who worked at the home. Both told us about the planned activities inside and outside of the home. This included poetry, balloon tennis, shoe polishing, music, arm chair exercises, singings, working with tools, discussing local landmarks and arts and crafts. We were told that sometimes people did not want to take part in the planned social activities of the day and that other pursuits and interests were encouraged to suit people's individual mood and wishes. An activities co-ordinator said "We try and find out what residents like to take part in and spend as much time as we can getting to know the residents." The home had a cinema lounge for film shows. On the day of the inspection people were joining in with making table decorations for Chinese New Year. A Chinese buffet was also planned to celebrate this event. During the inspection a person living at the home went out for lunch with their relative. The relative confirmed this was arranged regularly and enjoyed.

Staff had a good awareness of the home's complaints procedure and relatives and people we spoke with told us they could speak to the managers about any concerns they had. One relative we spoke with said, "I have no complaints and would find (staff member) and speak with them if I had a query about anything." Another relative told us they were waiting for the outcome of an investigation into a complaint they had raised and that this would be discussed with them at a formal meeting. We reviewed two complaints received and actions had been taken in accordance with the home's complaints' procedure.

One person who was visiting raised a number of concerns with us regarding the care and support for the person they were visiting. They told us these had been raised previously and during the inspection it was unclear whether there were any formal records around the actions taken. Following the inspection the provider and deputy manager were able to provide assurance around the actions taken previously and confirm that there had been no formal complaint received at that time. The management team took action to address the concerns following the inspection. The concerns have been discussed further with the person and appropriate actions taken to ensure the matters raised have been resolved. The need for further privacy and dignity training for ancillary staff is being arranged as this was an area that was deemed as needing improvement. The deputy manager acted swiftly in respect of the complaint and lessons learned to improve practice shared with the staff.

Good

Is the service well-led?

Our findings

There was a clear management structure in place. The home had a registered manager and they were supported by a deputy manager and visits from the provider. The registered manager and deputy manager had an active presence throughout the days we were inspecting and were well known by everyone. Relatives told us they were happy with the management arrangements in the home. Their comments included, "It's well run", "You can go to (manager) and (deputy manager) at any time, they do listen if you need something sorted" and "We are happy with everything."

Staff described Lakeside View as a good home to work in. Staff told us they were well supported and worked as a team. We saw staff meetings were held and these provided staff with an opportunity to share their views, to find out how the service was operating and discuss training needs. This helped to ensure staff were kept up to date. A staff member said, "I have worked here a long time and we give a very good standard of care." Staff were aware of the concept of whistle blowing and said they had confidence in the management team if they needed to speak up.

Feedback was sought from people living at the home and relatives. This included sending out customer satisfaction survey to relatives and holding meetings at the home. An analysis dated January 2017 of the completed surveys (40 distributed and 15 received) reported favourably regarding the service. Suggestions for improvements had been taken on board. For example, cabinets in ensuite rooms, an increase in cleaning hours, further development of the key worker role for staff and the provision of a more varied menu had been actioned. Comments received included, 'happy with care given', 'communication is good, 'confident in care given to relative' and 'lovely staff'. We were shown minutes of resident/relative meetings. These were held every two months and at different times to enable people to attend. We saw discussions had been held regarding social activities and choice of television programmes to suit all age groups at the home. A relative told us they attended regular meetings but could speak with the management team at any time.

We reviewed some of the quality assurance systems in place to monitor performance and to drive continuous improvement. This included a number of internal audits and also the home's response to external audits. For example, an external infection control audit. We looked at a number of audits which covered care practices, safe working and health and safety. For example, medicines, care planning, falls, nutrition, kitchen standards, control of infection, dining room experience, monthly room checks and maintenance. Any recommendations had been acted on to improve and monitor standards of practice. We saw the implementation of a new cleaning audit following guidance from an external infection control lead. The registered manager and deputy manager showed a good understanding of the auditing process.

There has been no recent provider audit/quality outcome review. The last one was completed in August 2016 and covered areas such as, dining experience, customer satisfaction surveys, risk assessments, care planning, social activities, quality assurance and meetings. It was agreed on inspection that the next provider audit would be completed by the end of February 2017 and a copy sent to us for our records. An action plan was drawn up in September 2016 in response to the audit and a number of actions were listed. These had not been signed off as completed though discussion with the registered manager during the

inspection identified a number of completed actions. We discussed with the registered manager 'signing off' the actions to provide a robust audit trail.

During the inspection we found the need to consider further development around the promotion of a dementia friendly environment. The registered manager said this would be addressed as part of the future development of the service.

Staff had access to a number of policies and procedures which were easily accessible. We found they were current and in accordance with current guidelines and 'best practice'.

The registered manager was aware of incidents in the home that required the Care Quality Commission to be notified of. Notifications have been received to meet this requirement.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating. 'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Lakeside View was displayed for people to see.