South West Care Homes Limited

Lake View

Inspection report

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Ratings

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

Overall summary

Lake View is a residential care home which provides personal care to a maximum of 29 older people, including those who may be living with dementia or who may have a learning disability. Lake View does not provide nursing care. People who live at Lake View access healthcare through local community health services.

At the time of the previous inspection two people living at the service were accommodated in a bungalow in the main house's grounds. This bungalow was not being used at the time of this inspection and all of the 19 people currently living at the home were accommodated in the main house. All of the people living at the home were living with dementia or a learning disability and three people were being cared for in bed due to their frail health.

Lake View is owned by South West Care Homes Ltd, which operates 11 residential care homes in South West England.

There was a registered manager in post. 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.

The home was last inspected on 5 and 6 November 2014 and was rated as requiring improvement. We found improvements were needed in the way medicines were managed; how care planning, risks to people's safety and mental capacity assessments were recorded; how infection control was managed; the training provided to staff; how the quality of the service was reviewed and how complaints were managed. We also found improvements were needed in relation the environment. Two breaches of the Health and Social Care Act 2008 (Regulated Activities) 2010 were identified. The provider sent us an action plan telling us what they were going to do to meet the regulations and we found at this inspection that improvements had been made.

Prior to this inspection we received information that staff were not wearing protective aprons or gloves when assisting people with personal care or while serving meals, as well as there being insufficient soap available for hand washing. We had asked the registered manager to look into these issues and they provided us with a report of the actions they had taken. During the inspection we saw staff wearing aprons and gloves when assisting people and when serving meals. Toilets and bedrooms had sufficient hand washing soap and paper towels.

The registered manager said the home had sufficient staff to meet people's daily care needs both during the day and night, and throughout the inspection we saw call bells were attended to promptly. People told us they received timely assistance during the mornings and when they rang their call bells. Staff told us they had time to meet people's needs and were not under pressure to rush when assisting people with their personal care. However, staff did not have time to sit with people and engage them in conversation or support them with meaningful activities. Other than the planned activities for entertainers to come in to the home several days a week, staff confirmed they only had time to provide spontaneous short interactions such as painting someone's nails. Also, it was not clear from people's daily care notes whether staff had spent time with people who were being cared for in their room. The results of recent questionnaires and meetings indicated people felt more social activities were needed to provide meaningful occupation for people during the day.

The registered provider confirmed they had plans to increase the staffing in line with guidance from specialist dementia care organisations. Following the inspection, the registered manager confirmed they were recruiting an additional member of staff into a 'social' assistant role.

We found the home to be clean and generally odour free, however, some of the chairs in the lounge room did not appear clean and were stained with food debris. The carpets in the hallways and in some bedrooms were still to be replaced and this had been arranged for later in the year. The joins in some carpets had been temporarily repaired to reduce the risk of people tripping.

People and their relatives where appropriate, were involved in planning their care both prior to their admission to the home and throughout their stay, and we saw, some people's involvement had been recorded at the time the plans were reviewed. However, for those people who were living with dementia and may not have been able to comment directly about the information in their plan, there was no evidence staff had explored whether they felt their needs were being met.

The care plans provided guidance for staff about people's preferences in how their care needs should be met and what they were able to continue to do for themselves. The plans also provided information about how people wished to spend their time and the things that were important to them.

Those people who were able to express their views told us they felt safe at the home. They said the staff were always caring, friendly and respectful and they were being well cared for. One person told us "yes, it's lovely" and another, "oh yes, I'm safe." When asked what would make life better for them at Lake View, people said, "nothing, I have everything I need" and "I can't think of anything, no I'm fine." For those people who weren't able to share their experiences with us, we saw them approaching staff and holding their hands, or smiling when staff approached them, indicating they felt safe in

Summary of findings

staff's company. We saw staff treating people with kindness and patience. Staff no longer wore a uniform to remove a potential barrier to forming relationships with people.

The home was currently being redecorated and clear signage had been placed around the home indicating where the toilets and bathrooms were. A further smaller seating area with a television was being created in the hallway to promote interaction between people. The front door had been disguised as a book case and the registered manager confirmed this reduced the risk of people who may be unsafe to leave the home unsupervised using this door. At the previous inspection, people told us their belongings were not always safe and other people wandered into their room. We saw locks had been fitted to the bedroom doors providing privacy and security.

Risks to people's welfare and safety had been assessed and management plans described how to reduce these, such as those associated with reduced mobility or with swallowing difficulties. People's personal emergency evacuation plans had been updated since the previous inspection and now held more detailed information about how to protect people in the event of a fire. Medication practices were safe and people received their medicines as prescribed. People had regular access to healthcare professionals such as GPs, and staff were observant for changes in people's usual self as an indication they may be unwell.

Staff recruitment processes were safe, with references from previous employers and police checks being carried out prior to staff starting to work at the home. Staff knew people well and told us they enjoyed working at the home and they were well supported by the registered manager. One staff member said, "I love my job. It's a nice place to work" and another said, "we want people to feel happy and comfortable, to know they matter."

Since that inspection, staff had received training in supporting people living with dementia, safeguarding people who may be vulnerable due to their poor physical or mental health and understanding the principles of the Mental Capacity Act 2005 (MCA). Throughout the inspection, we saw staff routinely ask people's consent before staff assisting them. We heard them say, "can I help you with that?", "have you finished, shall I take it" and "would you like to?" We saw some people were unable to make decisions over their care and required best interest decisions to be made for them by people who knew them well and healthcare professionals, where relevant. Records of these decisions were seen in people's files, although some had not been fully completed. Authorisation had also been sought to legally deprive some people of their liberty as the home used a keypad lock on the front door to prevent people who would be at risk if they were to leave the home unsupervised.

People told us they enjoyed the food at the home. Comments included "the food is very nice" and "yes lovely". We observed the lunchtime meal and saw some people could not remember the choice they had made the day before, and said they did not want the meal when it was presented to them. Staff provided them with the alternative, which they accepted. We discussed with the registered manager the way in which people who may have memory difficulties were supported to choose their meals. The registered manager agreed to change this. People would now be shown both choices at the time of the meal to allow them to choose which they preferred.

People, staff and social care professionals told us the home was well managed. People said they were listened to and felt able to discuss any issues of concern they may have with the staff and registered manager. Prior to the inspection, a number of social care professionals contacted us to inform us of the "excellent care work being carried out at Lakeview residential home." The company's philosophy is "to encourage and support our residents in making choices, in being independent." The registered manager recognised there were improvements to be made at the home and said they were determined to "continually improve". They had recently completed a Diploma in Health and Social Care at Level 5 and they regularly attended meetings with other care home managers in the local area where good practice and resources were shared.

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 safe.

People told us they felt safe. People were protected from the risk of abuse as staff understood the signs of abuse and how to report concerns.

Medicines were managed safely and people received their medicines as prescribed.

Risks to people were identified and staff were provided with information about how to manage these risks to ensure people were protected.

Staff recruitment practices were safe, to ensure as far as possible staff unsuitable to work with vulnerable people were not employed at the home

Good

Is the service effective?
The service was effective.

People told us they enjoyed the food at the home, however, the way in which people who may have memory loss were supported to choose their meals required improvement.

Staff had completed training to give them the skills they needed to ensure people's individual care needs were met.

People's rights were respected. Mental capacity assessments had been carried out and where a person lacked capacity to make an informed decision, staff acted in their best interests.

People had regular access to healthcare professionals. Staff were observant in changes to people's usual self as an indication they may be unwell.

Good

Is the service caring?
The service was caring.

People said the staff were always caring, friendly and respectful. People were treated kindly and with patience.

Staff knew people well and were able to describe how they wished to be supported.

Staff told us they enjoyed working at the home and they felt well supported.

Good

Is the service responsive?
The service was responsive.

Some people had not been consulted over planning their care. For those people living with dementia there was no evidence staff had explored whether they felt their needs were being met.

Requires improvement

Summary of findings

Staff had little time to engage people in social interaction or meaningful, activities. People's past social history was not recorded in detail in their care files.

People told us they knew how to make a complaint, who to raise a concern with and were confident any concerns they may have would be dealt with.

Is the service well-led?

Good

The service was well-led.

People and their relatives as well as healthcare professionals told us the home was well managed.

The registered manager recognised there were improvements to be made at the home and said they were determined to "continually improve".

The registered manager encouraged people and staff to share their views about the services provided at the home.

There were systems in place to assess and monitor the quality of care.

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 was planned to check whether the 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 08 October 2015 and was unannounced. One adult social care inspector undertook the inspection. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to and following the inspection we spoke with two health and social care professionals to gain their views of the service provided at Lake View. During the inspection we spent time with all of the people living in the home and we spoke with a visitor, four members of staff, the registered manager and the registered provider.

We used a number of methods to assess the quality of the care and support people were receiving. This included using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed three care plans, how medicines were managed, three staff recruitment and training files and documents related to the running of the home.

Good

Is the service safe?

Our findings

At the previous inspection in November 2014 we found improvements were needed to the way medicines were managed, how risks to people's safety were recorded and how infection control was managed. We also found repairs to some carpets were necessary. At this inspection we found action had been taken to address these issues.

Prior to this inspection we received information that staff were not wearing protective aprons or gloves when assisting people with personal care or while serving meals. We were also informed there were insufficient soap available for hand washing. We asked the registered manager to look into these issues and they provided us with a report of the actions they had taken. This included providing hand washing soap dispensers and reminding staff of the necessity of wearing protective aprons and gloves to control the risk of infection. During the inspection we saw staff wearing aprons and gloves when assisting people and when serving meals. Toilets and bedrooms had sufficient hand washing soap and paper towels.

We found the home to be clean and generally odour free, with one bedroom having a malodour that was being attended to by the care staff and the cleaner. Some of the chairs in the lounge room did not appear clean and were stained with food debris. The registered manager confirmed there were plans to replace some of this furniture. The carpets in the hallways and in some bedrooms were still to be replaced and this had been arranged for later in the year after the external repair and decoration of the home was completed. The joins in some carpets had been temporarily repaired to reduce the risk of people tripping.

Those people who were able to express their views told us they felt safe at the home. They said they were being well cared for and had no concerns. One person told us "yes, it's lovely" and another, "oh yes, I'm safe." For those people who weren't able to share their experiences with us, we saw them approaching staff and holding their hands, or smiling when staff approached them, indicating they felt safe in staff's company. Staff told us they had received training in protecting people and knew how to recognise signs of possible abuse. They confirmed they would raise any concerns over people's safety or welfare with the registered manager. They knew who to contact 'out of hours' or if the registered manager was not available.

People told us there were enough staff on duty to assist them to get up in the mornings and, if they rang their call bell, staff came within a reasonable period of time. One member of staff told us "we are not under pressure to rush in the mornings. People can get up whenever they want. We can take our time to assist them with their personal care properly, just as we would like."

Throughout the inspection we saw call bells were attended to promptly, however we saw staff had little time to sit with people in conversation or engage them in meaningful activities. The health and social care professionals we spoke with also shared the view that people's immediate care needs were being met but staff did not have time to spend "quality time" with people. One raised concerns whether people's care needs overnight could be met safely with the staffing arrangements as they currently were. At the time of the inspection there were 19 people living in the home, some of whom required the assistance of two staff to meet their personal care needs. On the day of the inspection in addition to the registered manager, there was a team leader, three care staff, one of whom left at 10:30, a cook and a cleaner on duty. During the afternoon there was a team leader and two care staff, and overnight there was one waking and one sleeping –in care staff.

We discussed the staffing levels with the staff and registered manager who said there were sufficient staff to meet people's care needs, overnight as well as during the day, as the sleep-in person assisted the waking night staff when necessary. The registered manager confirmed they regularly reviewed staffing levels with the care staff and used a 'dependency tool' to assess how reliant people were on staff to meet their care needs. We saw the assessment in people's care plans and they had been reviewed each month. The registered manager recognised staff did not have time to spend with people other than when undertaking care tasks or assisting with meals.

The registered provider confirmed they had plans to increase the staffing in line with guidance from specialist dementia care organisations. Following the inspection, the registered manager confirmed they were recruiting an additional member of staff into a 'social' assistant role. They would be responsible for preparing hot drinks during the morning and afternoon freeing care staff from this, and spending time with people in social and leisure activities.

We looked at the way the home managed people's medicines. People had been provided with a file containing

Good

Is the service safe?

information about the medicines they were taking, including why they had been prescribed and what the possible side effects were. People told us they received their medicines when they needed them and we observed some people being given their medicines. This was done safely with people being told what the medicine was for. The team leader told us some people preferred not to be "stood over" when taking their medicines, and they watched discreetly from a short distance to ensure the medicine was taken. We saw no gaps in recording the medicines given to people in the medicine administration records. However, the reason why people had requested 'as needed' medicines, such as pain medicine, was not recorded. It is good practice to record why someone required these medicines to allow staff to monitor their health and comfort and to assess the effectiveness of the medicines. Staff confirmed they would now record this on the administration form rather than just in the daily care notes. For those people who required medicines with varying doses, this was managed safely with clear records of the dose to be given obtained from the GP. Guidance regarding the applications of creams was clear, with body maps indicating where the cream was to be placed and a separate administration record was used for their application.

Audits of the medicines held in the home and the administration records ensured these were accurate. Staff confirmed they had received training in safe medicines practices and certificates were available in staff files. The registered manager undertook regular assessments of staff's competence to ensure their practice reflected the home's procedures and they were knowledgeable about safe practices.

We reviewed how risks to people's safety had been assessed. People's personal emergency evacuation plans had been updated since the previous inspection and now held more detailed information about whether the individual could respond to the fire alarm and what the safest course of action would be for that person. Other risks, such as those associated with poor mobility or swallowing difficulties were clearly identified. For example, one person's risk assessment indicted they were at risk from developing pressure ulcers as they were no longer able to change their position. The plan clearly described the equipment necessary and guided staff on how to reduce the risk of this person's skin becoming sore. This person's daily care notes recorded their change of position during the day and night and there was a pressure relieving air mattress on their bed.

Staff recruitment processes were safe, with references from previous employers and police checks being carried out prior to staff starting to work at the home. This reduced the risk of employing staff who may be unsuitable to work with vulnerable people.

The registered manager confirmed they and the other registered managers within the company were to undertake training with a specialist dementia care organisation. They described the changes currently being made and those planned to make the home more suitable for people with dementia. The front door had been disguised as a book case and the registered manager confirmed this reduced the risk of people who may be unsafe to leave the home unsupervised using this door. Instead people saw the doors leading to the conservatory and the garden where it was safer for them to be outside. Further plans were in place to make the garden more accessible and completely secure.

At the previous inspection, people told us their belongings were not always safe and other people wandered into their room. We saw locks had been fitted to the bedroom doors providing privacy and security.

Good

Is the service effective?

Our findings

At the previous inspection in November 2014 we found 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 had not received any training in this area.

Since that inspection, staff had received training in supporting people living with dementia, safeguarding people who may be vulnerable due to their poor physical or mental health and understanding the principles of the Mental Capacity Act 2005 (MCA). We saw certificates confirming this training in the staff files we looked at and staff were able to describe to us people's rights to make decisions about how they wished to be supported. Throughout the inspection, we saw staff routinely ask people's consent. We heard them say, "can I help you with that?", "have you finished, shall I take it?" and "would you like to?" before assisting people.

The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision needs to be made involving people who know the person well and other professionals, where relevant. We saw best interest decisions had been made for some people however, the documentation relating to the decision was only partly recorded. The decision under review and those involved in assessing what was in the person's best interest had been clearly identified but the final outcome was not fully recorded. For example, it had been agreed with one person's GP they required a certain medicine to maintain their health. As they were reluctant to take medicines, it was necessary to give this covertly as the person was unable to understand the consequences of not receiving this medicine. However, the section to record the decision had not been completed. The home had obtained advice from the pharmacist about how best to give the medicine covertly, such as whether it could be given in a liquid form or crushed and added to food, showing the medicine was being given safely.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. This includes decisions about depriving people of their liberty so that they get the care and treatment they need, where there is no less restrictive way of achieving this. At the time of our inspection, some people were being deprived of their liberty, with the use of a keypad lock at the front door, and applications had been made to the local authority's DoLS team for authorisation.

People told us they enjoyed the food at the home. Comments included "the food is very nice" and "yes, lovely". There was a choice of two dishes at lunchtime and people had been asked the evening before which meal they would like. While this worked well for those who were able to understand what the meals were and remember the meal they had chosen, we saw some people ask for something else when the meal was presented to them. Staff offered them the second choice which they accepted. We saw people were able to ask for second helpings and this was provided. We discussed with the registered manager the way in which people who may have memory difficulties were supported to choose their meals. The registered manager agreed to change this. People would now be shown both choices at the time of the meal to allow them to choose which they preferred.

The cook confirmed they were able to provide alternatives to the two main meals, such as soup, omelettes and baked potatoes. The cook had a card which highlighted each person's preferences and any special dietary requirements, such as low sugar diets. People were offered drinks and snacks throughout the day, and we saw people enjoying fruit, biscuits and cakes. The cook confirmed three courses were provided at teatime: soup, a choice of a hot or cold meal, and a dessert. People were also encouraged to have a snack before bedtime with a milky drink to support people to have a good night's sleep and not wake in the night hungry. Care plans identified people who may be at risk from not eating enough or from not recognising when they are hungry or thirsty. For example, one care plan stated, "I won't say if I am hungry. I need to be prompted to sit at the table to eat." Where necessary food and fluid charts were used to ensure people had sufficient food and fluid intake to maintain their health.

People had regular access to healthcare professionals such as GPs, occupational therapists, chiropodists, district nurses, opticians, and dentists. Staff were observant for changes in people's usual self as an indication they may be unwell. For example, one person's daily care notes

Good

Is the service effective?

indicated they "weren't themselves and had been sleepy for a few days" and staff had requested the GP to visit as they felt the person would not be able to tell them if they felt unwell.

New staff confirmed that they had received an induction when they had first started work at the home and were working towards completing the Care Certificate. This certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. Staff confirmed they received regular supervision and appraisals and we saw records of these in their files. A training matrix was used to identify the training staff had received and when updates were needed. The matrix indicated several training events had been held this year to ensure staff had the skills and knowledge to care for people safely.

Good

Is the service caring?

Our findings

Those people who were able to share their experiences with us spoke highly of the care they received. They told us the staff were always caring, friendly and respectful. One person said, “she’s lovely” indicating a member of staff, another said, “the staff are really nice.” For those people who were unable to share their experiences of living in the home, we saw people were treated kindly and with patience. We saw one member of staff dancing and singing with someone who had difficulty expressing themselves. We saw the person was enjoying the contact with the staff and they were smiling and joining in with singing. We also saw a member of staff support someone who had fallen. They sat next to them on the floor, asking them if they were in pain and reassuring them an ambulance was coming. The staff spoke quietly and calmly to the person, holding their hand to provide comfort and telling them they were safe.

The registered manager, in the provider information return stated, “all staff are encouraged to treat Lake View as their home, treating the residents as they would treat their family”. As a result of consultation with people, the staff no longer wore uniforms as they felt these could be a potential barrier to forming relationships with people.

Although staff were not seen sitting with people in conversation, when they did walk through the lounge room, they spoke to people and asked them if there was anything they needed. We saw one person say they wanted a cup of coffee and the staff member brought this to them on their return through the lounge room. Staff walked up to people who weren’t able to communicate their needs and placed a hand on their arms to check with them they were alright.

One visitor told us they were happy with the care their relative received and confirmed they had a good relationship with the registered manager and the staff.

Staff knew people well and when asked about the care needs of the people whose care files we looked at they were able to describe these. Staff told us they enjoyed working at the home and they felt well supported by the registered manager. One staff member said, “I love my job. It’s a nice place to work” and another said, “we want people to feel happy and comfortable, to know they matter.” They told us their caring role was about “making this feel like home” and “respecting people.”

Lake View was able to care for people at the end of their lives with the support of the person’s GP and the community nursing team. Anticipatory medicines were requested when a person was identified as nearing the end of their life to manage people’s symptoms. These medicines help people to experience a pain free and dignified death.

Requires improvement

Is the service responsive?

Our findings

At our inspection in November 2014 we identified concerns in relation to care planning and how complaints were managed. At this inspection, we found some action had been taken to address these issues. We identified improvements were required in involving people in contributing to planning and reviewing their care, as well as providing more social contact and meaningful activities for people.

People and their relatives where appropriate, were involved in planning their care both prior to their admission to the home and throughout their stay. Some people's involvement had been recorded at the time the plans were reviewed. However, for those people who were living with dementia and may not have been able to comment directly about the information in their plan, there was no evidence staff had explored whether they were happy to receive the care and support provided by the home and whether they appeared contented living at Lake View.

Although staff knew people well, people's past social history had not been recorded in the care files we looked at. It is important people's history is recorded and shared, particularly those people living with dementia, to enable staff to engage them in conversation or to understand the conversations they may be trying to initiate, and also to encourage people to be involved in meaningful activities which they have been known to enjoy in the past. For example, one person's file said, "(name) does not enjoy taking part in activities provided by the home". However, there was no further explanation of this person's interests or whether staff had explored what they might find enjoyable. The registered manager confirmed they were exploring contact with community organisations that could provide individual interest to people such as Friends of the RAF.

It was not clear from the daily care notes whether staff had spent time with people who were being cared for in their rooms. Personal care tasks and assistance with meals were recorded but there was little evidence of any social interaction. Staff said they took time with people when assisting them with their personal care, allowing time for conversation, but had little time to spend with them outside of these care tasks.

The care plans provided guidance for staff about people's preferences in how their care needs should be met, what they were able to continue to do for themselves and whether people were reluctant to receive assistance. For example, one person's care plan identified they became anxious when receiving personal care and their plan guided staff to "allow (name) to wander around the bathroom." The plans also provided information about how people wished to spend their time and the things that were important to people. For example, one person's care plan indicated they "liked to be quiet, sit in a quiet area and not be asked a lot of questions", while another person's said, "I like pink things" and we saw this person had pink toys on their bed.

Although staff had little time to sit in conversation with people, they said they did try to spend some quality time with people. For example, one staff member said, "I've got 10 minutes, I could do (name's) nails." Activities by entertainers coming into the home were planned several times a week and included art and craft work, some of which was displayed in the lounge and dining room, musical entertainment and visiting pets. The registered manager brought their dog into the home and people enjoyed this. On the day of the inspection, we saw people enjoying an interactive music session, with people encouraged to play a musical instrument, sing and dance. People were enjoying spending time with each other, were comfortable in each other's company and chatted and laughed together. The person who preferred to "be quiet" came to stand at the lounge room door and watched people singing.

People told us they knew how to make a complaint and who to raise a concern with. People said they knew the registered manager well and felt their concerns would be dealt with. One person said "I can talk to her (the registered manager)". When asked what would make life better for them at Lake View, people said, "nothing, I have everything I need" and "I can't think of anything, no I'm fine." A visitor told us the staff listened to them and their relative. They said their relative had felt their room was dark when the scaffolding had been erected to undertake external repairs to the building. Staff had offered the person another room and the person was very pleased they were able to move to a brighter room. The home had received five complaints since the previous inspection. These had been recorded and the actions taken by staff to resolve the issue were clearly identified.

Good

Is the service well-led?

Our findings

At the previous inspection we identified improvements were required in how people and staff were involved in developing the service and reviewing the quality of care being provided. We also found improvements were needed in relation to maintaining confidentiality and dignity. At this inspection we saw action had been taken to address these issues.

Minutes of recent resident and staff meetings showed the registered manager encouraged people to share their views about the services provided at the home. Visitor satisfaction surveys had been sent out in April 2015, but the registered manager confirmed only 20% had been returned. Suggestions for improvements from the meetings and the survey related to providing more social and leisure activities and involving people in meaningful activities during the day. The registered manager confirmed action was being taken to address this.

Those people who were able to comment, a family member and the staff, told us the home was well managed. Prior to the inspection, we received a letter from seven social care professionals who informed us of the "excellent care work being carried out at Lakeview residential home." They went on to say, "It is our impression that she has a thoroughly sound value base which means she puts client well-being at the centre of her practice. We feel that (name of the registered manager) caring professionalism and, when the situation demands, commitment to going the extra mile, has made a palpably positive contribution to the quality of care provided at Lakeview." This was further confirmed with the results of a professional survey from August 2015.

The company's philosophy is "to encourage and support our residents in making choices, in being independent."

The registered manager recognised there were improvements to be made at the home and said they were determined to "continually improve". They had recently completed a Diploma in Health and Social Care at Level 5 and they regularly attended meetings with other care home managers in the local area where good practice and resources were shared. Regular audits of records, such as care plans and accidents enabled the registered manager to ensure documents were accurate and up to date, and people were protected from avoidable harm.

There was a clear management structure within the home, with team leaders having specific responsibilities, such as ordering medicines. Staff worked well as a team to make sure people got what they needed. For example, we saw staff discussing with each other who would assist someone with their meal while others supported people on the dining room, as well as telling each other where they were going and what they were doing. These conversations were held discreetly, taking into account people's privacy.

People were provided with information about the home and the service provided, such as visits by a hairdresser and a chiropodist, including the cost, as well as the contact details for local GP surgeries. Included in the information pack were copies of the homes policies and procedures people may find useful such as the complaints procedure and the privacy and dignity policy.

The service had received a food hygiene visit in November 2014. They had been awarded a rating of five. This was the highest rating and showed the service maintained very good hygiene.

The registered manager had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.