Lakeside View 18 LLP

Lakeside View

Inspection report

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Ratings

Overall rating for this service	Not sufficient evidence to rate
Is the service safe?	Not sufficient evidence to rate
Is the service effective?	Not sufficient evidence to rate
Is the service caring?	Not sufficient evidence to rate
Is the service responsive?	Not sufficient evidence to rate
Is the service well-led?	Not sufficient evidence to rate

Overall summary

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 2012, and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) that looks at the overall quality of the service.

This was an unannounced inspection. Lakeside View Nursing Home is a care home that provides nursing care for up to 38 people. The home provides nursing care for people who are living with dementia and/or a mental health care need.

The home overlooks the marine lake in Southport and is within walking distance of Southport town centre. Accommodation is provided over four floors. The dining room and three lounges are located on the ground floor. The home has a passenger lift and parking to the front of the building.

The home was registered with CQC on 27 March 2014. This was the first inspection of the home since its registration. Because the service had been registered for a such a short period of time we did not have enough evidence to award a rating.

Summary of findings

A registered manager was in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The service had processes in place to minimise risks to people whilst ensuring their independence was promoted. Staff received training in adult safeguarding and were clear about how to identify and report any actual or suspected abuse. The registered manager had a good understanding of the Mental Capacity Act (2005) and how it should be used to safeguard people.

People's health care needs were responded to in a timely way and people could see a health care professional when they needed to. People's dietary needs were being met and people told us they were satisfied with the food.

People told us they were treated with dignity and respect. They said the staff were kind and that they felt listened to. Families were pleased with the care. They were involved in developing the care plans if their relative lacked the mental capacity with decision making.

Most people had recently moved into the home and staff were getting to know their likes/dislikes and preferences for how they liked to spend their day. Information about the home and service was available in an 'easy-read' format.

A complaints process was in place. One complaint had been received since the home opened and it had been dealt effectively to the satisfaction of the complainant.

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?

Not sufficient evidence to rate

The service is safe. People living at Lakeside View Nursing Home were safe because they were protected from bullying, harassment, avoidable harm and potential abuse. Staff understood what abuse was and they were aware of what to do if they suspected abuse had occurred.

There were sufficient staff members on duty at all times to meet people's personal care needs, nursing needs and to keep people safe throughout the day and night. Effective recruitment checks were in place to ensure staff were suitable to work with vulnerable adults.

Is the service effective?

Not sufficient evidence to rate

The service is effective. People told us staff responded to their individual healthcare needs in a timely way. They said they received their medication at a time when they needed it.

People, families and visiting healthcare professionals were confident staff had the knowledge and skills to provide effective care. People were supported to access healthcare from a range of external professionals.

People were satisfied with the food. They had sufficient to eat and drink throughout the day and night.

The registered manager and staff had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Two people living at the home were subject to a Deprivation of Liberty Safeguarding (DoLS) order. Appropriate documentation was in place regarding the DoLS authorisations.

Is the service caring?

Not sufficient evidence to rate

The service is caring. We observed that staff were caring and treated people with dignity and respect. This was supported by the people, families and visiting professionals we spoke with.

Staff communicated with people in a kind and respectful way. They were warm and friendly in the way they engaged with people. We observed that there was always a member of staff in the lounge to support people if they needed it.

We found through discussions with families and by looking at care records that people and/or their families were involved with making decisions about their care and support.

Summary of findings

Is the service responsive?

The service was responsive. Most people had recently moved into the home and staff were getting to know their them, including their preferences for social and recreational activities.

The people and families we spoke with were aware of how to make a complaint or raise a concern. They were confident their concerns would be dealt with effectively and in a timely way.

Not sufficient evidence to rate

Is the service well-led?

The service is well-led. The home had been open for only a short period with the majority of people moving in from the end of May 2014. Although we could see that systems and processes to monitor the quality of the service were established, most had been in use for a short period of time. Some processes, such as medication audits and meetings for people living at the home had not yet started.

A process was in place for managing accidents and incidents. The registered manager analysed the accidents and incidents to monitor for any emerging themes or patterns.

Staff had a good understanding of the whistleblowing policy and in what circumstances they would use it. They told us management was approachable and supportive and, they were given time to read through people's care plans.

Not sufficient evidence to rate

Lakeside View

Detailed findings

Background to this inspection

We visited Lakeside View Nursing Home on 15 July 2014. This was an unannounced inspection which meant the staff and provider did not know we would be visiting.

We spent time with eight people and invited them to share with us their views and experience of living at the home. We spoke with three family members who were visiting the home at the time of our inspection. We also spoke with four of the care staff, a member of the catering team, the provider (owner) and the registered manager.

We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not verbally communicate with us. We had a look around the building, including a visit to the kitchen and some people's bedrooms. In addition, the inspection involved looking at a wide range of records, including the care records for four people, two staff recruitment files and records to support how the home was being managed.

The inspection team was made up of a Care Quality Commission (CQC) inspector 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 service.

Before our inspection we reviewed the information we held about the home. We contacted the commissioners of the service and Healthwatch to obtain their views of the service. We spoke with four healthcare professionals who visited the home on a regular basis.

We did not receive a provider information return (PIR), which CQC requested from the provider prior to the inspection. The provider and registered manager said they had not received emails requesting this. When we checked the email address for the service held by CQC it was incorrect. Therefore the PIR request had been sent to an incorrect email address. This has now been clarified and rectified.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

Not sufficient evidence to rate

Is the service safe?

Our findings

The majority of people we spoke with had limited experience of the home as they had only lived there for a short period of time. In addition, some people were unable to verbally express their views about the safety of the service due to needs associated with memory loss. They told us they felt safe living at the home. One person said, "Yes, I am treated well." Another person told us, "They [staff] are lovely to me."

People had some awareness of the medication they were taking. One person said, "I take [tablets] regularly for my back. I get them when I need them." Another person said, "I know what they [tablets] are for and I get them when I need them."

We spoke with the family of one person who lived at the home. They said their relative was supported in a safe way because there were always staff available to provide support. They liked the building because it was spacious and light to move about in safely. One of the family members said, "It is wonderful here, very good. We looked at other places and this was the best."

The four health care professionals who visited the home on a regular basis told us that they were satisfied with how the home managed individual risk and how people were treated.

Most of the people who lived at the home were unable to provide a view about the staffing levels due to needs associated with memory loss. One person said, "In my opinion they don't have enough staff." However, family members were satisfied with the staffing levels. One family told us their relative, "Received a lot of one-to-one time." The professionals we spoke with had no concerns about the staffing levels. We observed through the day that there were sufficient staff on duty to ensure people were safe. We observed staff supporting people in a safe way.

There was a registered nurse and three care staff on duty during the day to provide care for 14 people. We asked the registered manager how staffing levels were determined. The registered manager advised us that as people moved into the home the staffing levels would be increased. We noted from the care records that a dependency assessment was carried out for each person and these had been reviewed on a monthly basis.

Assessments and care plans were in place for people with risks associated with their health and welfare needs. These included risks associated with nutrition, mobilising and skin integrity. Some people smoked and clear arrangements were in place to ensure people were safe when they smoked and with managing their cigarettes and lighter. Most people's risk assessments and care plans were signed by the person or their representative. Some were not signed and the registered manager explained this was because they had only recently moved into the home. Staff told us they were still getting to know the risks for the people who had recently moved in.

We looked at the care plan for a person who had very recently moved to the home and had on occasions displayed unpredictable behaviour. The care plan to guide staff in how to manage these incidents was very lengthy and detailed. We discussed with the registered manager that if care plans are not illustrated in a clear and concise way, key strategies for managing the particular risk could be missed in the detail. The manager agreed that the care plans were lengthy and said she would relook this.

Risk assessments were in place for people who used bedrails. These clearly indicated that bedrails were used to keep the person from falling out of bed rather than as a form of restraint. Because people lacked capacity with decision making the assessments were signed by a family member indicating their agreement for use of this equipment.

We spoke with staff about adult safeguarding. They had a good understanding of what abuse was and were able to clearly describe how they would respond if they identified potential abuse. Staff told us and records confirmed that the staff team appointed since the home opened had received training in the safeguarding of vulnerable adults.

Staff explained the recruitment process to us and confirmed that they had been subject to checks, which were made to ensure staff were suitable to work with vulnerable adults. The staff personnel files we looked at confirmed recruitment and induction practices supported this. An induction checklist was also in place for agency staff who worked at the home.

Not sufficient evidence to rate

Is the service effective?

Our findings

People told us staff responded to their individual healthcare needs in a timely way. They said they could see a district nurse or GP when they needed to. A visiting healthcare professional told us the staff contacted them in a timely way so that any healthcare concerns were assessed and treated at the earliest stage possible. One person did say, "I've not had my healthcare reviewed but my memory is probably worse." A family we spent time with were satisfied with the standard of care their relative received.

The four healthcare professionals we spoke with were satisfied with the care provided at the home. One professional told us, "Everything is okay. Patients' needs are being very well met." Another professional said, "I have no concerns. The staff are proactive in the way they look after the patients." We looked at four people's care records and could see that detailed records were maintained of consultations with healthcare professionals, such as the GP, district nurse and community mental health nurse. People had a physical health check each month that included a check of their blood pressure, temperature, pulse and weight.

Although none of the people we spoke with could recall having their dietary needs assessed, we noted that nutritional assessments had been completed for each person when they were first admitted. People's dietary preferences were recorded in the care records and the registered manager confirmed these were shared with the catering team so that the catering team had an understanding of people's preferences.

We sat with a group of people who lived at the home in the dining room at lunchtime. The people we spoke with did not know what was on the menu and said they had not been asked what they would like for lunch. One of the people told us, "There's no choice, everyone gets the same." A menu was not displayed anywhere. We asked the registered manager about this. We were shown the menus which the registered manager said were usually displayed on the table. We were advised that on the day of the inspection there had been a mix up with the menu for the day and an alternative meal was prepared to that listed on the menu. To avoid confusion a menu was not displayed that day. The registered manager and staff said people were routinely given a choice at each meal time but confirmed it had not happened on the day of the inspection because of the mix-up with the menu. The registered manager said they would look into the matter with the catering team.

We asked if people had been involved with developing the menu and were advised that this had not happened yet. The registered manager said they had plans to revise the menus based on people's preferences but a food survey had not yet occurred as the majority of people had only moved into the home recently.

Overall, people were satisfied with the meals. A person said, "The food is very nice. Sometimes we get steak and chips." Another person told us, "I've never had a problem. The majority [of the food] is pretty decent." Furthermore, a person said to us, "It's a big enough portion, I would ask for more if I was hungry."

People who needed assistance with eating and drinking were supported by staff in the dining room. Sufficient staff were available to ensure people were supported with their meal in a timely and unrushed way. Some people were on special diets, such as a soft or diabetic diet. When we looked at care records we saw that there were risk assessments and care plans in place for people with special nutritional and dietary needs. These assessments and plans had been reviewed for people who had lived there longer than four weeks. We also noted that external healthcare professionals were involved in the development of some people's nutritional plans.

People and their families told us they were confident staff had the skills and knowledge to support people with their specific needs. A family member said, "The manager comes across as very able and the staff seem capable in their job." When asked about the ability of staff, a person said to us, "They are excellent." The staff and the registered manager told us that they were up-to-date with training the organisation required them to undertake. We confirmed this by checking the training records. The documentation had been developed for undertaking staff supervision and appraisal. Because the staff team had been recently recruited only a few supervision sessions had taken place. Staff we spoke with who had been in post the longest confirmed they had received supervision.

The registered manager had attended training in the Mental Capacity Act (2005) and demonstrated a good understanding of the Act. The Mental Capacity Act (2005) is

Not sufficient evidence to rate

Is the service effective?

legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. Equally, most of the staff team had attended training and had a good understanding of the principles and their responsibilities in accordance with the Mental Capacity Act (2005). Some newly recruited staff had limited understanding of the Act but they said they would go the manager if they were unsure about something.

Two people living at the home were subject to a Deprivation of Liberty Safeguarding (DoLS) order. One person had an urgent authorisation in place and the other person had a standard authorisation in place. DoLS is part of the Mental Capacity Act (2005) 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. Appropriate documentation was in place regarding the DoLS authorisations. It was clear from our discussions with the registered manager and from review of the care records that the registered manager worked closely with the local DoLS coordinator, families and the professionals involved with the care of each person.

We noted from the care records that a GP had agreed to a person taking their medication covertly. This meant medication was disguised in food or drink so the person was not aware they were receiving it. This approach was taken as the person was refusing important medication for their health. We spoke with the GP who confirmed they had agreed this method for administering medication. We could not see a care plan regarding this and the registered manager told us the plan was discontinued as the person was no longer refusing medication so it did not need to be administered covertly.

Not sufficient evidence to rate

Is the service caring?

Our findings

People told us they were treated with dignity and respect. A person said, “They [staff] are very kind.” When speaking about the staff another person said, “They are lovely to me.” People said they were encouraged to be independent and said that staff listened to them. A family we spoke with were pleased with the care provided at the home and said the staff were caring and supportive.

Throughout our visit we heard staff communicate with people in a kind and respectful way. We observed that there was always a member of staff in the lounge. Staff interacted with people in a warm and friendly manner. We noted staff offering people support before they needed to ask for assistance. The staff we spoke with demonstrated a good understanding of how they treat people with dignity and respect. A member of staff said management would not tolerate staff treating people in an uncaring way.

Due to needs associated with memory loss, the people we spoke with could not recall whether they had been involved in developing their care plans. One person told us, I’ve not been involved in my care plan. I’m told what they [staff] are going to do.” Another person said, “I’ve not been involved. I didn’t know about care plans.” However, from our discussions with families, the registered manager and access to care records, it was clear care planning was not developed in isolation of the person or their representative. The person or their family representative had signed the care plans and various consent forms, such as consent to the administration of medication and the use of bedrails. A process was in place for reviewing care plans on a monthly basis.

Not sufficient evidence to rate

Is the service responsive?

Our findings

We observed staff positively engaging people with recreational activities. Staff knew what activities people liked. For example, a member of staff was dancing with a person and said the person loved to dance. Another member of staff said they had recently found out that a person liked bird watching and planned to get a bird table for the person so they watch the birds through the window. A person told us they liked cleaning and we observed the person setting the tables for lunch and cleaning up afterwards. The person's care records acknowledged that they liked cleaning and involving the person in this type of activity was recognised in the care plans.

A structured programme of activities was in the process of being developed as staff were getting to know people's preference for recreational and social activities. Two staff were responsible for organising activities but both had been in post a short period of time and were getting to know the people living at the home. During the inspection we heard the activity coordinators taking to people about their preferences for activities. We observed that people seemed interested in a proposed trip to an art gallery a few days after the inspection.

Some information about the home was available in an 'easy read' format. For example, the daily menus were available in large print and included pictures of the meals. Information about the home and its facilities (referred to as a 'Service User' guide) was located in each bedroom. It included an 'easy read' pictorial version as well as a longer version. There was a bookcase in one of the lounges but none of the books were in large print. Staff told us they were arranging for the mobile library to visit the home on a regular basis.

The 'Service User' guide included a section on how to make a complaint. The registered manager had received one complaint since the home opened. It was from a person living at the home. We checked the record of this and saw that the registered manager responded to the complaint in a timely way and to the satisfaction of the complainant. From our conversations with people and their families, we determined they were aware of what to do if they had a concern. A family told us the registered manager was approachable and they felt confident that a concern would be resolved quickly and effectively.

People's care needs were assessed prior to moving to the home and further assessments were conducted once they had moved in.

Not sufficient evidence to rate

Is the service well-led?

Our findings

Lakeside View Nursing Home was registered with CQC on 27 March 2014. A registered manager was in post from the time of registration. The aim of the service is to provide nursing care for people who are living with dementia and enduring mental health needs. The registered manager explained that it was the intention to develop a separate unit within the home for people with a young onset dementia. The provider was currently looking into this development with local health and social care stakeholders.

Although the home was registered to accommodate 38 people, 14 people were living there at the time of the inspection. Four people had moved in between the end of March and mid May 2014. Ten people had moved in from the 25 May 2014 with two people moving in two days before the inspection. The registered manager highlighted that a large proportion of their time involved preadmission assessments, assessing people's needs once they moved in and developing care plans. Alongside this, staff were being recruited as the numbers of people living at the home increased.

The care records informed us that people and/or their family representative were involved in developing their individual care plans and the home was in the early stages of actively involving people in the broader development of the service. A customer satisfaction survey had started and nine completed questionnaires had been returned. The respondents included people living at the home, their relatives and professionals who visited people living there. Overall, the feedback was positive. Comments from families included, "It is early days" and "All good so far." Meetings to seek the views of people living at the home had not yet started.

The healthcare professionals we spoke with were satisfied with how the home was run.

Systems were in place to monitor the support for staff. We could see from the training records that most staff were up-to-date with the training their organisation required them to complete, and they had completed dementia care training. One staff meeting had taken place since the home was registered.

People's care plans and risk assessments were reviewed each month. A process was established for auditing the care records and we could see that one care record had been audited since the home was registered. Other service audits that had been developed included an audit of wheelchairs, hoists and walking aids. These audits were undertaken in June 2014. The registered manager advised us that a medication audit was due to start.

A structured process was in place for managing accidents and incidents. This was being used appropriately by staff. The registered manager showed us how they analysed the accidents and incidents to monitor for any emerging themes or patterns.

A fire risk assessment had been completed in March 2014. A process of fire safety checks was in place but we observed these were not up-to-date in terms of frequency of the checks. The registered manager advised us that the fire service visited the home in the last month and made recommendations about how the checks should be undertaken and the paperwork that should be used. The home's maintenance person was in the process of developing the schedule of checks and paperwork in line with the recommendations. Environmental risk assessments were undertaken in March 2014.

The staff we spoke with were aware of the policy framework for the home and how to access a policy if they needed to. In particular, they had a good understanding of the whistleblowing policy and in what circumstances they would use it. Staff told us they had been well supported in terms of training since they started working at the home. They said it was taking time to get to know each person's needs and routines. They told us management was approachable and supportive and, they were given time to read through people's care plans