Blackcliffe Limited

The Lakes Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Lakes Care Centre is a care home. It is registered to provide personal and nursing care for up to 77 people aged 65 and over, across three units. One unit provides nursing care, whilst the other two units provide residential care. All units have single bedrooms and there are a range of communal spaces.

People's experience of using this service and what we found
Medicines were not being safely handled. Risks were not being fully assessed and necessary action to mitigate risks was not being taken. There was not always enough staff, and robust recruitment processes were not always being followed. Improvements to infection control practices were noted but further work was needed to ensure processes and good practice were being consistently followed. Lessons were not always being quickly and effectively learnt.

People were not always given the right support with food and drink. The meals being served had improved, but further work was required to improve choice. Not all staff had completed the necessary training but felt supported in their role. Various areas of the home were not suitable, and the registered manager took immediate action to remove people from one area of the home due to concerns regarding fire safety, following our first day of inspection. We found repeat issues regarding protecting people from the risk of hot surfaces, and security around the premises. The provider and registered manager had not identified these shortfalls despite systems for checks being in place. Health care input was not always being followed-up in a timely way.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support good practice.

Systems had been implemented to support oversight in the home but were not being carried out effectively. Regular checks of the environment had not identified shortfalls found, and care plan audits had not identified inconsistencies and inaccuracies within people's care records. A new management team were in place since our last inspection, but little progress had been made to improve the quality of the service. The provider did not have robust systems in place to assess the effectiveness of action they had taken to improve the service. The provider was holding meetings with families and although communications had improved it was not evident that all families were clear, and up to date about changes happening in the home.

People were not always well treated, and they did not always get the care and support needed in a timely way. People's dignity was not always considered and there was no consistent approach to promoting independence and allowing people privacy. Some staff were caring and knew people, but we did not always see positive interactions between staff and people.

People were not always receiving person-centred care, or care that was appropriate for their needs. A programme of activities was in place, but people still told us they were bored. People were often left sat in front of the television, with limited task-based interactions with staff, for most of the day. End of life care plans were in place, but further work was required to ensure these were proactively completed in a person-centred and detailed way. End of life decisions were not always subject to review if people showed signs of improvement.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Inadequate (published 15 February 2022).

The provider completed an action plan after the last inspection to show what they would do and by when to improve and worked closely with commissioning services. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We have found evidence that the provider needs to make improvements. Please see the full report.

Enforcement
We have identified breaches in relation to how people are treated, and given personalised care suitable to their needs; how the service meets the requirements of the mental capacity act; how risk and medicines are managed within the service; how people are supported with what they eat and drink; how the premises is safely managed; staffing and recruitment of staff; and how the service is managed and improvements made.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Lakes Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by three inspectors, a medicines inspector and inspection manager and an Expert by Experience over the course of five days. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Lakes Care centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Lakes Care Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced on all five days of inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included information of concern we had received from whistle-blowers and notifications the service is required to submit regarding any significant events happening at the service. We sought feedback from the local authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used information gathered through multi agency meetings held and updates from the provider about their progress with their improvement action plan. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We reviewed staffing levels and walked around the building to ensure it was clean and a safe place for people to live. We observed how staff supported people and provided care.

We spoke with 13 people who use the service, 7 relatives and 19 members of staff including the registered manager, unit managers, nurses, care workers, and auxiliary staff including kitchen staff, maintenance and activity workers. We spoke with the nominated individual and other members of the senior management team over the course of the inspection. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with 3 agency staff.

We reviewed a range of records including 10 people's care records and multiple medication records. We looked at 4 staff files in relation to recruitment, training and support. A variety of records relating to the management of the service, including policies and procedures were examined.

We continued to review evidence and seek further clarification during and following the inspection. We asked the registered manager and provider to send any further information for consideration following feedback. No further information was provided at that time.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Inadequate. The rating for this key question has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection we found people's medicine was not being properly and safely used. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Medicines were not being safely handled.
- Good practice guidance was not always being followed. For example, handwritten MAR were not consistently scrutinised by two staff to ensure they were accurate, and times of administration were not being maintained to ensure where medicines required specific time intervals this was followed.
- According to the home's records one person's medicine to treat an infection was not administered in the right way.
- According to the home's records carers did not always apply prescribed emollient creams in the way prescribed.
- Storage arrangements for some medicines that are controlled drugs did not meet the requirements of the Misuse of Drugs (safe custody) Regulations. The registered manager has now ordered an appropriate cupboard.
- The provider was unable to provide appropriate evidence to demonstrate that all staff administering medicines had relevant checks of their competency to do so.
- One person who had capacity was left with medicines to take later. Records did not demonstrate this had been risk assessed or incorporated into this person's care plan. Staff were signing that this had been administered although they may not have witnessed this medicine being taken.
- Records of the receipt, administration and disposal of medicines were not completed accurately so it was not possible to account for medicines. During the inspection we found that a large quantity of a medicine liable to misuse was unaccounted for. When we brought this to the home's attention the incident was investigated and reported to the controlled drugs accountable officer for the Yorkshire and Humber region.
- During the inspection we also became aware of a medicines error where a person was placed at risk of serious harm through being given another person's medicines, including controlled drugs, by an agency nurse. Learning was discussed with the registered manager as the correct processes were not being followed. This is currently being investigated.

People's medicines were not always being properly and safely managed. This placed people at risk of harm. This was a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored at the right temperatures
● Guidance for staff on the administration of 'when required' medicines had been reviewed and each person had a protocol stating when their medicine(s) were needed.

Assessing risk, safety monitoring and management

At our last inspection we found risks to people were not being assessed or action taken to reduce this as much as possible. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● The provider had not taken the necessary action to monitor and reduce risk as needed.
● At our last inspection we found examples of furniture, which was not suitably secured, including radiator covers to protect people from contact with hot surfaces. At this inspection we found the necessary action to protect people had not been taken and there were multiple areas where radiators did not have covers. This included communal areas and people's bedrooms. Some of these had been specifically raised with the provider as part of our enforcement action. Systems of checks were in place but had not been effective.
● At our last inspection we found people were not being consistently protected from known risks, such as regular checks when they were a falls risk. At this inspection we found shortfalls remained. We could not ascertain that people were subject to the right levels of support, supervision and that the right equipment was in place and being effectively used. We found lap belts were not consistently used when people were transported using wheelchairs, where slings were left in place whilst people were in wheelchairs eating their meals, and where room sensors to alert staff that a person was moving or had fallen were not always appropriately placed to alert staff in those circumstances. Records did not show people were being checked on or supported with repositioning or pressure relief where needed. The registered manager acknowledged there were a number of challenges with the current recording systems.
● At our last inspection we found that assessments of risk were not always accurate or reflected in people's records of care, and different systems to manage and mitigate risk were being used across the service. At this inspection we found continued inconsistencies in how risk was managed. Some people had specific care plans to guide staff on managing risk, whilst others did not have similar care plans regarding their area of needs. Risks and needs were not always clearly reflected on the digital care planning systems.
● Inspectors found multiple examples where people who were at risk of choking were not having the correctly modified diet. Advice given by speech and language therapy had not been incorporated into people's care plans or effectively shared with staff supporting these people with food and drink.

People were not being protected from potential risks. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection we found there was not enough suitably qualified, competent, skilled and experience staff in place across the service to meet people's needs. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● There was not always enough staff to meet people's needs.
● There were delays in how people were being provided with personal care. For example, we found people were not consistently having regular baths and showers. One person told us, "I can book a shower or jacuzzi

but if there are a lot of people it can be over two weeks [before I have one]." There were times when inspectors needed to intervene as people were complaining they were thirsty and did not have access to a drink and staff were either too busy to respond to the person, or the person had no way to raise an alert with staff.
● Staff were consistently busy and frequently task focused. People complained they were bored, and staff did not have time to provide social stimulation and emotional support.
● People told us they often had to wait for support. We noted delays in when breakfast was served although several people living at the service were early risers and were waiting for this in communal areas. We completed an evening visit and found several people were unhappy whilst waiting for staff to support them to bed.
● One person told us, "I don't know if there is enough staff." A family member told us, "It can be difficult visiting at weekends, there is no one on reception and you have to wait until staff answer the phone or someone appears near the door. It got so bad that I stopped visiting at weekends."
● The provider had a dependency tool in place and told us they were currently overstaffing. However, our observations were that staff were constantly firefighting and struggling to meet people's needs at busy times of the day, juggling other tasks including answering phone calls and this had led to some of the shortfalls we observed. Feedback from staff raised shortfalls in staffing levels as their primary concern.

There were not enough suitably qualified, competent, skilled and experienced staff in place across the service to meet people's needs. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was not following robust recruitment processes.
● We found one member of staff was left alone with people for a significant period of time prior to having received full checks with the disclosure and barring service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer which helps employers make safer recruitment decisions. The provider had completed a risk assessment to mitigate the risk, but this assessment was not being followed.
● The service was not following a robust recruitment process in line with their own policies. Action was not always taken to ensure application forms were fully completed, and that references were validated.

Staff were not robustly recruited. This was a breach of regulation 19 (Fit and proper person employed) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not always safeguarded from potential harm.
● During the inspection we identified several people who were not receiving the diet they required as assessed and prescribed by speech and language therapy. People's care plans had all been subject to regular reviews and audits, but these processes had not identified these important discrepancies.
● People generally told us they felt safe. One person told us, "Most of the staff are very good. It depends who is on." Another told us, "I feel safe here and the staff do the best they can when they are in the mood."

Preventing and controlling infection

At our last inspection we found the prevention, detection and control of the spread of infections were not implemented effectively. At this inspection we found some improvements but there were still some shortfalls noted.

● At the last inspection staff did not always wear personal protective equipment (PPE) correctly. At this inspection we noted some improvements in mask wearing but still found numerous occasions where staff removed their mask whilst talking to each other. We also noted staff were not complying with the provider's policies and saw instances of staff wearing false nails and eyelashes, and jewellery.
● Staff did not always ensure they had the appropriate equipment to ensure good infection control. We saw instances where staff had not taken appropriate bags for managing soiled laundry and continence products when supporting people in their bedrooms and bins did not always have appropriate bags in place.
● The home was generally clean and tidy. There were some areas of the home, such as certain bedrooms, which had unpleasant odours which did not disappear once the room was cleaned.
● The registered manager understood current guidance for infection prevention and control and other principles for managing infection outbreaks.

The service was supporting people to have visits from friends and family in line with the guidance in place at the time. The home encouraged families to visit people in their bedrooms in order to manage foot fall within the home.

Learning lessons when things go wrong
● The provider had not implemented effective systems to ensure lessons were learnt following our last visit.
● The required changes to the environment had not yet been completed meaning that people were not being protected from known risks, such as scalding from hot surfaces, accessing the sluice and other areas of hazard and having access to thickening powders.
● The provider had systems in place for updating managers and supporting lessons to be learnt across their services. However, this information did not always lead to actions being taken in the service.
● Processes were in place to analyse accidents and incidents for themes and trends and this was being completed on a monthly basis. However, due to recording shortfalls we could not be certain all incidents or near misses were being accurately recorded to allow for a robust analysis.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Inadequate. The rating for this key question has remained Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection we found people's nutritional and hydration needs were not always being met with the provision of a suitable and balanced meal which was in line with people's assessed needs and preferences. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 14.

- People were not always supported to eat and drink enough, in line with their assessed needs.
- Several people were not receiving the correct diet as assessed by speech and language therapy (SALT). We found instances where people were placed at risk, as information about modified diets and advice to reduce the risk of choking had not been correctly incorporated into care plans. Staff were not aware of the correct information. We raised safeguarding concerns for 3 people and requested that all people on a modified diet were reviewed to ensure they were receiving the correct diet.
- The quality of food provided at the home had improved although feedback from people indicated there was still room for improvement. One person told us, "The food is reasonable." A family member commented, "[Family member] is a bit finicky with their food and doesn't eat much but they have put on weight, so I have no complaints there." There were pictorial menus in place, but these were not being consistently used to support people to make choices around what they wanted to eat. People were being asked to make choices about their meals the day before.
- Hydration stations were in place so that people could access drinks when they wanted them. We found various other juices were available to people, although these were not always being stored correctly. People cared for in bed, and during the night, did not always have access to drinks. On several occasions, we asked staff to provide drinks to people who we were speaking with in their bedrooms. Fluid records were being kept and for some people there were shortfalls in how much they had drunk. There was no oversight to ensure people at risk of dehydration were supported to drink sufficiently.
- People did not always get their meals when they wanted them. Some people who woke early had to wait several hours before breakfast was provided. People's nutritional and hydration needs were not always being met in line with their assessed needs. This was a continued breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection we found staff were not consistently receiving appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out their duties. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Staff had not completed all the necessary training to ensure they were able to meet people's needs.
● The registered manager was aware that improvements were required. The provider said they were in the process of sourcing an alternative training provision.
● The provider told us staff had received competency assessments, but we were unable to confirm this in some areas, such as the administration of medicines. The nominated individual told us they would arrange for the clinical consultant to complete these with all staff responsible for administering medicines.
● We observed staff did not always have the training, skills and experience to meet people's needs. We identified shortfalls in how staff supported people in various areas including how they promoted choices, treated people with dignity and respect, met people's nutritional and hydration needs and safely used equipment to reduce risk.
● Staff generally told us they felt well supported by their line manager. Most staff had recently received supervision and the registered manager had a rolling plan to ensure supervisions and appraisals were completed in line with the provider's policy. Some staff felt that improvements were still needed to ensure accurate communication and updates about the service.

Staff had not always completed the necessary training or had assessments of competency to ensure they provided safe care and support to people. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

At our last inspection we found the premises and equipment were not always suitable for the purposes being used, and properly used and maintained. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 15.

● At the last inspection we found the provider had not made the expected progress to improve the premises.
● At this inspection we found some work had been completed on one unit which, after the first day of inspection, was taken out of commission due to fire safety issues. Some work had been completed in the communal areas of other units, but other work had not yet been completed as advised. People's bedrooms remained dated and in need of redecorating. This included stained and dirty walls, and damaged flooring and equipment.
● At our last inspection we found areas of the service were being used for storage. At this inspection areas had been cleared of equipment. However, we found areas of the service which were not suitably secured including sluice areas, cleaning cupboards; and externals doors leading to unsecured areas of the outside which were not always suitably secured. We freely accessed the units on the first day of inspection as the service was not secured. Unsecure premises can place people at risk in several ways.
●The provider had not taken timely action following a fire risk assessment. Fire door release systems were not in place in some areas of the service to ensure they closed in case of an emergency. These issues were raised with the registered manager who arranged for the people living in the unit to move onto another unit. Throughout the inspection we found fire doors held open with equipment and furniture rather than a suitable fire door release mechanism. We arranged for the fire service to complete their own inspection of

the service to ensure the premises were safe for people.

Premises and equipment were not always suitable for the purposes being used, and properly used and maintained. This was a continued breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection we found people's care and treatment was not being consistently provided with the consent of appropriate people and in accordance of the mental capacity act 2005. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some improvements had been made but this was not consistent across the home.

● Consent forms to ensure people consented to care and treatment had been implemented. People who had capacity had signed these, and where people lacked capacity appropriate family members had been involved. However, this was not yet fully completed for everyone living at the service.
● There was a lack of consistency in assessments and care plans for people who lacked capacity to make decisions. Some people had detailed decision specific capacity assessments and care plans which reflected capacity and, where DoLS were present, any conditions that were in place. However, this was inconsistent across the home and some people's care plans were confusing and lacked the necessary level of detail to show how the requirements of MCA were being met.
● Where people had restrictions, such as medicines being given covertly (hidden in food and drink), if they refused to take medicine, there were no clear systems for recording how and when these restrictions were used. It was not evident that decisions about giving medicines covertly were reviewed with relevant health care services at regular intervals, or that consideration to which medicines would meet the criteria to be given covertly reviewed.
● Records were insufficient to show that people who had capacity were supported to make their own decisions. One person told us, "I have not asked but I feel as though I can't go out." Another said, "I would like a choice of things to do." However, another people told us, "I can get up when I want. I stay in my room as that's the way I like it."

The Systems in place did not demonstrate the provider was acting in accordance with the mental capacity act. This was a continued breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed and reviewed regularly. However, these assessments were not always accurate or incorporated into care records, and staff were not always aware of correct information.
● One family member told us, "We have reviews once a month to see everything is okay. I come in and see one of the managers in a meeting and everything is normally okay." Feedback from families was that communication had improved.
● Records did not always demonstrate that people or relevant others were involved in reviews and this experience varied across the three units.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● At our last inspection we found that records did not demonstrate people were being referred to healthcare services, that referrals were followed up and advice was incorporated into people's care plans. At this inspection we found similar issues and were not assured that timely action was always taken. For example, one person had an eye infection and although eye drops had been requested from the doctor's surgery this request had not been followed up, leaving this person without the medication they needed for several days. Other experiences were more positive and one family member told us, "My family member had a catheter fitted and was getting regular UTI's (urinary tract infections) so the staff, in consultation with the district nurse, suggested they stop having that as a trial and there has been a lot less UTIs."
● Where wound care was managed by the home there was evidence of wound management plans and reviews and wounds were seen to be improving. However, where people's skin integrity was a potential area of risk, it was not always evident that robust care plans were in place. Records did not demonstrate that people were having the pressure relief and skin creams they needed to reduce the risk of any skin damage.
● People and families felt confident that medical input would be sought when needed. One family member commented, "[Family member] has had access to doctors and the hospital when needed and they let me know as soon as possible when something is wrong."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Requires Improvement. The rating for this key question has remained Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not always treated well.
- At our last inspection we found people did not have regular baths or showers as they wanted and complained of being bored. At this inspection we found these issues remained. One person commented, "Best not to ask too many questions about showers. No one bothers. I have a good swill in the sink." Another person commented, "I would like to go out more. I feel hemmed in and lost." Several people commented that there was not much to do.
- At our last inspection we found that people did not always get the care they wanted, and certain aspects of care was not person-centred. At this inspection we found similar themes. Some people's care plans contained person-centred detail, but this was not consistent for everyone and we observed multiple instances where people were treated the same without consideration to their specific needs or preferences. For example, it was not evident that consideration had been given to the specific needs of people living with dementia who were all provided with adapted coloured crockery although this may not have been needed.
- We observed that interactions between people and staff varied significantly. At times we saw very positive and kind interactions, but at other times staff were task focused, interactions were less positive, and staff spoke about people in derogatory terms.
- People gave us mixed feedback about the staff and the care they received. One person told us, "Most of the staff are very good. It depends who is on." Another person said, "Staff treat me ok. I don't give them any problems. I don't complain." One person told us, "I user the buzzer if I need anything. Sometimes I have to wait a bit if they are busy, but I have to put up with it and accept it."
- Records did not demonstrate that people always got the right frequency of checks. We observed staff were often too busy to complete all the tasks allocated.

People were not always treated with dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

- Systems had been implemented to enable people to share their views and make decisions about their care.
- The home had implemented a resident of the day scheme. This is a scheme which allows people to feedback about a variety of different factors affecting them including food and activities and is an opportunity to review care plans. This scheme had not yet been embedded across all units of the service and at the time of the inspection it was difficult to assess the impact the scheme may have for people.

● People did not always feel involved in making decisions about their care. One person commented, "I would like to go out more. Now I've got to do what I'm told to do and when I'm told to do it."
● Some care plans contained details about people's likes and preferences. However, it was not always evident that staff were knowledgeable about people's preferences or followed care plans. Care plans did not always easily and accurately identify this important information staff needed to know about people they supported.

Respecting and promoting people's privacy, dignity and independence
● People's privacy, dignity and independence was not always respected or promoted.
● People often had their bedroom doors left open whilst they were in bed and asleep. It was not evident from r people's care records this was their choice.
● Care plans for some people contained guidance around promoting independence and what people could do for themselves. From our observations we found that staff were not consistently following these care plans, and this was not consistently in place for everyone living at The Lakes.
● Consideration was not always given to people's dignity. We found people cared for in bed did not always have a full set of pyjamas or night wear and at times were left with no clothing on their bottom half. There was no evidence that this was their preference on review of these people's care plans.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question Requires Improvement. The rating for this key question has remained Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection we found that systems for ensuring people's care and treatment was appropriate, met their needs and reflected their preferences was not being used effectively. This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 20078 (Regulated activities) regulations 2014. At this inspection we noted some improvements to person-centred care planning, but not enough improvement had been made to ensure that people had care that was appropriate and met their needs.

- People had a variety of care plans but there was an inconsistent approach to care planning and not all care plans were accurate and reflected the person's current needs.
- Some people had condition specific care plans which were detailed and provided the guidance staff needed to support that person. However, others with similar conditions had less specific plans or did not have such plans in place.
- Information about people's needs was not always accurate in care plans. For example, one person had physiotherapy advice following a hospital admission which detailed exercises that the person needed to complete to aid their rehabilitation. The specifics had not been incorporated into the person's care plan and records did not demonstrate that staff were supporting the person with this need.
- Consideration to equipment being used was not person-centred. We found several occasions where bed rail covers were not consistently in place and there were no assessments of the associated risks, such as entrapment. We found crash mats and sensor buzzers were not always appropriately placed to ensure staff would be alerted should a person have a fall.
- Work was ongoing to personalise care plans and gain information about people's life history. The provider and registered manager recognised further work was required to develop and improve care plans.
- Some people had to wait before they could have breakfast. We saw that on some occasions people were not getting their breakfast until mid-morning although they had been awake and ready for breakfast for several hours.

People were not receiving personalised care which was consistently appropriate and met their needs and preferences. This was a continued breach of regulation 9 (Person-centred care) of the Health and social care Act 2008 (Regulated Activities) regulation 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have

to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People had communication care plans and there was consideration to the equipment and resources people might need. One person's care plan referred to using flash cards with them to aid communication, and others care plans included information related to the vision and hearing equipment people might need. However, we found several instances where people did not have this equipment with them, for example, glasses.
● We observed occasions when staff spoke with people in a way they could access. For example, by ensuring they were face to face with the person at their level. However, we also saw occasions where staff failed to communicate with people at all, when supporting them.
● Staff had been asked to complete accessible information standard questionnaires and this information would be used to support staff in their job roles.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● At our last inspection we found people lacked stimulation and told us they were bored. At this inspection we found that although there was some improvement in activities being available, people remained bored.
● There were activity workers in place who, with help of staff, provided some level of stimulation for people. However, throughout the inspection we observed limited activities available and many people were left sat in communal areas unstimulated. The television was on, but most people were not watching this. One person told us, "There's nothing to do. I just sit and watch TV." Another person complained, "There is nothing to do but sit and behave and shut up and do as you are told. It's boring. That's how I feel."
● Activity staff had completed some activities, including taking people outside for walks, and arranged for a member of clergy to visit the service.

Improving care quality in response to complaints or concerns
● Records of complaints and concerns were being maintained.,
● The registered manager had recently started an open door surgery where people and families could drop in to speak with them and discuss any matters and raise any concerns they may have. Records to enable oversight and evidence action was taken in response to any issues shared, was in place.
● Feedback from people and families was mixed with some people feeling able to raise concerns and others feeling their concerns would not be listened to or action taken. For example, one person told us, "I have no complaints, but they would probably just ignore me if I did." Whilst a family member told us, "I have no complaints."

End of life care and support
● The service had the required paperwork and processes to support people actively receiving end of life care. People not receiving end of life care did not always have detailed end of life care plans in place.
● One person was receiving this support and the required documentation was in place to ensure staff knew how best to support them. Access to medication, to ensure people remained comfortable was in place. A family member spoke very positively about support staff were giving.
● A person who had been placed on an end of life pathway by the hospital had improved whilst being supported at the service. However, their needs had not been fully reassessed. For example, the importance of one person's choking risk was not the priority for that person whilst they were receiving end of life care, and the focus at that time was on maintaining comfort. This had not been reviewed and reassessed as the person's condition improved.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Inadequate. The rating for this key question has remained Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

At our last inspection we were not assured that the provider was able to identify, address and sustain improvement with the service through sufficient oversight and suitable governance arrangements. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made and the service continued to be in breach of this regulation.

- At our last inspection we found numerous breaches of regulation, rated the service inadequate and placed the service into special measures. We used our enforcement powers in response to our concerns. At this inspection we found that the required improvements to keep people safe had not been made.
- The service had completed an action plan and was providing updates to the local integrated care board. However, actions marked as complete had not been scrutinised by the provider to ensure they had been effectively completed. For example, the provider had signed off actions regarding staff competency assessments. However, the provider was unable to provide evidence everyone had undertaken the necessary checks of competency.
- Oversight was insufficient to ensure improvement actions had been implemented effectively and were improving the lives of the people living at The Lakes. For example, the provider had introduced pictorial menus to help promote meaningful choices at mealtimes but were not used by staff to promote choice and people were expected to make decisions about what they wanted to eat 24 hours in advance. The registered manager told us that they had identified this, but action had not yet been taken to ensure people were able to make meaningful choices about what they ate.
- Audits and checks of compliance were in place but these had not been sufficiently robust to identify the shortfalls found during the inspection in terms of the safety and quality of service.
- The registered manager provided assurances that steps would be taken to learn lessons following our feedback. However, following our last inspection and despite a variety of ongoing support and new management, the provider had not demonstrated they were able to learn and improve, or that actions taken could be effectively implemented and embedded across the service or that action would be sustainable.

Systems to identify, address and sustain improvements within the service through sufficient oversight and suitable governance arrangements were not in place. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

● At the last inspection we found that people did not consistently get person-centred care and care records were not always individualised and person-centred. At this inspection we found there was greater involvement of people and families through the resident of the day scheme, but this was not consistently implemented and recorded across the units. Some care records were personalised, but this was not consistent.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood their legal responsibilities and the requirements of the duty of candour. However, we were unable to evidence that systems were in place to support this process, as recording systems were not suitably robust. Further work was required by the management team to ensure curiosity when investigating incidents.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Since our last inspection a permanent manager had been recruited and they had completed the registration process with CQC. There were also other new members of the management team.

● Not everyone was clear about the management arrangements. One person told us, "I don't know who is in charge. I ask the staff if I need anything." A family member told us, "I know the manager. When I have met them, they are fine and approachable."

● Robust systems to ensure suitable lines of accountability which were appropriate were not being followed by staff. During the inspection we completed an out of hours visit but this was not suitably escalated to those responsible for the running of the service, and it was not evident that all staff were familiar with the lines of responsibility in the service.

● Daily meetings took place to discuss any areas of risk across the units. These meetings helped identify areas of risk and any regulatory responsibilities, such as statutory notifications which needed to be submitted to CQC, or safeguarding referrals which needed to be made. These meetings had not yet been embedded, and at the time of inspection did not always happen if the registered manager was not on site.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider had implemented a newsletter. One family member commented that these provided them with updates about the service and told us, "In the newsletter they have said they recognise they need more staff and they say they are recruiting."

● The provider was holding family meetings via the internet. This was used as an opportunity to update families about changes in the home. Not all families were aware of or chose to be involved in this process.

● People were unclear how they were involved in developing the service. One person told us, "I don't know about any improvements" Another person said, "I don't really get involved. My family member does all that." However, relatives and friends were clearer and felt involved, with one relative telling us, "I've had surveys and questionnaires."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People were not receiving personalised care which was consistently appropriate and met their needs and preferences.

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People were not always treated with dignity and respect.

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The Systems in place did not demonstrate the provider was acting in accordance with the mental capacity act.

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People's medicine was not being properly and safely used. People were not being protected from potential risks.

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	People's nutritional and hydration needs were not always being met in line with their assessed needs

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	Premises and equipment were not always suitable for the purposes being used, and properly used and maintained.

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems to identify, address and sustain improvements within the service through sufficient oversight and suitable governance arrangements were not in place.

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	Staff were not robustly recruited.

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	There were not enough suitably qualified, competent, skilled and experienced staff in place across the service to meet people's needs. Staff had not always completed the necessary

training and had assessments of competency to ensure they provided safe care and support to people.

The enforcement action we took:

We took enforcement action and placed conditions on the providers registration.