Minster Care Management Limited

The Lakes

Inspection report

Duncote
Towcester
Northamptonshire
NN12 8QA

Tel: 01327352277
Website: www.minstercaregroup.co.uk/homes/our-homes/duncote-hall

Date of inspection visit:
10 April 2019

Date of publication:
20 June 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: The Lakes is a provides residential care for up to 47 older people living with dementia. There were 43 people receiving care at the time of the inspection.

People's experience of using this service:

● The provider failed to have sufficient oversight of the home as there were failings in the quality and safety of people's care.

● People were not protected from the risks of abuse as staff and the registered manager had failed to recognise or report allegations of abuse, unexplained injuries and poor moving and handling; they had not alerted the relevant authorities.

● Staff did not consistently ensure people were supported to eat their meals. People were at risk of losing weight and dehydration.

● The provider did not employ enough staff to meet peoples' needs; they relied heavily on agency care staff. Recruitment of staff was on-going.

● People's experience of care differed depending upon how many permanent staff were on duty. People living with dementia did not always respond well to agency staff as they did not know them well. Permanent staff showed kindness in the way they spoke and reacted to people's anxiety.

● The provider failed to ensure agency staff had a suitable induction to the service, employment checks, training and competencies required to carry out their roles. Both agency and permanent staff had not always received the training and supervision they required to provide care that met people's needs.

● Staff were not adequately deployed to meet people's needs. People's dignity was not always maintained as their personal care was not always carried out in a timely way.

● The provider was not working within the principles of the MCA. They had not identified people who required a Deprivation of Liberty Safeguards (DoLS) assessment or made the appropriate applications.

● Staff did not always have information about people's needs as people's risk assessments and care plans did not always reflected their current needs. The registered manager had started to update the care plans.

● People did not always receive their medicines in a safe way. Staff did not always follow the provider's medicines policy.

● People living with dementia had access to substances that are hazardous to health as toiletries including denture cleaner was readily accessible in people's rooms.

● People did not receive care that reflected their personal preferences such as diet, bedding and clothing. The registered manager recently introduced deployment of staff that reflected people's preference for female care staff.

● People had not had the opportunity to express their preferences or wishes for their end of life care.

● People had not been supported to express their views about their care or be involved in creating their care plans. However, the registered manager had recently written to relatives to invite them to people's reviews.

● People and their relatives had not been asked for their feedback. People did not have any involvement in the running of the home.

● People's verbal complaints were not recorded or responded to. The registered manager did not always follow the provider's complaints procedure.
● The provider did not have adequate systems to assess, monitor, evaluate and make changes to improve the service. The provider failed to have systems in place to evaluate the quality and effectiveness of deployment of staff.
● The home was purpose built to meet the needs of people living with dementia. However, not all areas of the home were adequately used for the purpose they were intended.
● People were supported to access planned healthcare. Staff were prompt in referring people to their GP when they showed signs of ill health. Staff followed infection control procedures.

Why we inspected: We brought forward a planned inspection as we had received information of concern from families, staff and the local authority.

Enforcement: The provider was in breach of 10 regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 and two regulations of Care Quality Commission (Registration) Regulations 2009.

Full information about CQC's regulatory response to the more serious concerns found in inspections and appeals are added to reports after any concerns found in inspections and appeals have been concluded.

Follow up: We will continue to monitor the service and work with partner agencies. The provider will be instructed to provide action plans and reports.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not always effective Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not responsive Details are in our Responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led Details are in our Well-Led findings below.	**Inadequate**

The Lakes

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
This inspection was carried out by one inspector, an assistant 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 care service; people living with dementia.

Service and service type:
Residential home for older people.

The service has a manager registered with the Care Quality Commission. This means the registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: Unannounced

What we did:
We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification provides information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people living in the home.

During this inspection we spoke with six people using the service and eight visiting relatives. We spent time observing people's care and how staff interacted with them. We also spoke with eight members of staff including the provider's representative, registered manager, three care staff, chef, maintenance and administration staff. We also spoke with a visiting community nurse.

We looked at the care records of 14 people who used the service including daily records, medicines records and the assessments and care plans. We also examined other records relating to the management and running of the service. These included four staff recruitment files, training records, supervisions and appraisals. We looked at the staff rotas, complaints, incidents and accident reports and quality monitoring audits.

We arranged for some policies, provider's quality assurance report, complete list of all admissions and discharges and a newly designed accident form to be sent to us after the inspection visit. We also sought further clarification of the contents of the fire register, weight analysis and discharges and deaths data. We received these in a timely way.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse:
- The provider did not have suitable systems in place to recognise or report abuse.
- Staff had not reported incidents of suspected abuse or improper treatment. Staff had recorded 12 incidents of unexplained injuries between January and April 2019. These had not been referred to the relevant agencies, such as the local safeguarding team.
- Staff had not reported two incidents of physical or possible sexual abuse between people using the service. Staff had recorded incidents but had not referred these to the relevant agencies, carried out welfare checks or taken steps to prevent further occurrences.
- The registered manager had not reported an incident of inappropriate behaviour by agency staff as seen during a local authority visit in March 2019.
- The provider's policy did not contain information staff required to raise a safeguarding alert. For example, the contact details of the local safeguarding team, or instructions on how to contact them to raise an alert.
- The registered manager did not maintain comprehensive records of safeguarding alerts, the investigations or outcomes.
- Staff had received training in safeguarding but had not applied their training in practice.

The provider failed to have suitable systems in place to protect people from potential abuse or improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment

Using medicines safely:
- People did not always receive their medicines in a safe way. Staff did not always follow the provider's medicines policy.
- The provider did not provide staff with clear instructions or protocols for when it was appropriate to administer 'as required' medicines. Where people had been given sedatives and pain medicines 'as required' staff did not record their rationale for administering these or record the outcome. People's daily notes did not reflect why sedatives had been given, some people were given sedatives every night without a reason being documented. People were at risk of receiving 'as required' medicines such as sedatives when this was not always suitable or required.
- People requiring time critical medicines did not always receive these at the prescribed times.
- The provider did not ensure handwritten medicines records had been signed to demonstrate these had been checked against the prescription. People were at risk of not receiving all their medicines as prescribed.
- Although staff had received training in medicines management, and their competencies checked, staff did not follow the provider's medicine procedures to ensure the safe administration of medicines.

● The provider carried out monthly medicines' audits, however, these audits did not identify the issues found at inspection.

The provider failed to ensure there were suitable systems in place for the safe management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment

Staffing and recruitment:
● The registered manager did not hold records of all agency staff induction, recruitment checks and training. The records that were available did not demonstrate agency staff had undergone the required enhanced recruitment checks. Agency staff did not receive supervision or have their competencies checked. People were at risk of receiving care from agency staff who did not have the relevant recruitment checks and training to provide safe care.
● The registered manager did not always follow the provider's recruitment policy during recruitment and selection processes for permanent staff. Staff recruitment files did not contain all relevant information to demonstrate that staff had the appropriate checks in place.

The provider failed to ensure all staff had undergone the relevant recruitment checks and had the skills and competencies to provide safe care. This is a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Fit and proper persons employed.

● The provider had vacancies for care staff which were covered by agency staff. The provider had employed regular agency staff where they could with a view to permanent employment. Recruitment of staff was on-going.
● The provider calculated people's dependency and provided enough staff to meet their needs. However, staff were not deployed to provide people's care where needed or supervised to ensure they were providing safe care. One relative told us, "There aren't enough staff. I have fed other residents [other than their own relative]. I was once asked by a carer to watch the lounge for her as she had to pop out for a second."
● People did not receive their personal care or support to eat and drink in a timely way as staff were not deployed to provide care when required. One relative told us, "As a family we feel that sometimes [name] is invisible, [name] is quiet and no one notices them. [Name] can sit in a wet pad for ages, until it is sodden and dripping."
● Staff did not always have the skills and knowledge to provide safe care. We observed agency staff carry out unsafe moving and handling. We reported this to the registered manager and we raised a safeguarding alert.
● Some agency staff did not know how to communicate with people living with dementia. We observed permanent staff intervening where agency staff failed to communicate with people effectively, and people were refusing care. One relative told us some staff were unable to communicate properly, they said, "One resident was trying to converse with [agency staff] who only had monosyllabic responses."

The provider failed to ensure there were enough staff deployed with the right skills and competencies to meet peoples' needs. This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Staffing.

Assessing risk, safety monitoring and management:
● Staff did not always review people's risk assessments when their needs changed. For example, one person

was no longer mobile and received all their care in bed. Their risk assessments and care plans did not reflect this. People were at risk of receiving care that did not meet their current needs.
● People's care plans did not always provide detailed information for staff to mitigate known risks. The registered manager had started a programme of improving the care plans following a quality monitoring visit from the local authority in March 2019.
● Information provided to staff at handover did not always reflect people's current needs, there was a risk that staff would not have enough information to provide safe care, or care that met people's needs.
● People's mobility needs for evacuation from the home, such as in the event of a fire did not reflect the current occupancy of the home or reflect people's current needs. There was a risk that not all people would be accounted for in an emergency.
● The provider had not protected people from substances that could be hazardous to their health. People living with advanced dementia walked into all areas of the home where they had access to denture cleansers and toiletries; they were at risk of accidentally ingesting these.

The provider failed to ensure all people's risks were assessed and staff had information on how to mitigate these risks. This is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

● The provider had systems in place to regularly carry out environmental and health and safety checks, including water and fire safety checks.

Learning lessons when things go wrong:
● The provider and registered manager did not have sufficient oversight of safeguarding and incidents to learn from these. There was no system in place to recognise when things went wrong or prevent future occurrences.

Preventing and controlling infection:
● Staff had received training in infection prevention. They wore personal protective equipment such as gloves when providing personal care to help prevent cross infection.
● The provider carried out regular infection control audits and completed actions where issues had been identified.

Requires Improvement

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

Requires Improvement: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations have not been met.

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

- People did not receive enough food and drink to meet their needs.
- People who required assistance to cut up their food or eat did not receive the support they needed.
- People had lost weight, staff had referred people to their GP and dietitian for advice. Kitchen staff followed health professionals' advice by preparing fortified food and drink, however, staff did not ensure people received their prepared foods. One person required foods fortified with cream, however, this had not been provided. The registered manager told us this was because the person was not used to food with cream in as they usually had a Mediterranean diet. The person continued to lose weight.
- The chef told us they regularly made "milkshakes for [name], I've left it in the fridge [for care staff to use], but it's not been touched." They told us they had not made the milkshake in the last two days as staff did not give it out.
- Two relatives told us they came into the home daily to help their relatives by cutting up their food and encouraging them to eat as the staff did not do this. One relative assisted three other people with cutting up their food too as they sat on the same dining table.
- Relatives told us they had regularly seen most people (in the dining room) were unable to eat their meat as they were unable to cut this up themselves. We observed people trying to eat their roast potatoes and meat with their fork but were unable to do so, these were left on their plate; staff had not offered to cut up their food.
- Relatives told us they were not sure people were always getting their meals. One relative told us, "I feed my [relative] quite often, it takes a long while, one time a carer [staff] told us [relative] had eaten a whole plate full of food in 15 minutes, I question the veracity of that comment." We also observed staff taking over 30 minutes supporting this person to eat, as they ate slowly. Another family member commented, "I was here for two hours last Sunday and no one came to see if [relative] was alright, they thought she had had her lunch when they did come but she hadn't, I wonder if she would have been fed had I not been here."
- People were not encouraged to be independent when eating as staff did not provide adapted cutlery or plate guards to assist them to eat.
- Staff did not respect people's dietary preferences. One person living with dementia required full support with their meals; their care plan stated they did not eat red meat or chicken. However, staff recorded on their food chart they had eaten red meat and chicken daily.
- Staff did not accurately record what people ate and drank. We observed staff assisting a person to eat whilst they were in bed. Staff did not record what they had eaten all day, despite being on a food and fluid chart. Staff had recorded the person had also drank half a cup of tea, but the tea cup was still full.
- We observed staff offered people drinks frequently but they did not support people to drink. One person

had been left with their drink in their bed, this had spilt and wet their bed. Staff had not noticed.
● Staff did not have all the information they required to ensure people received foods that met their needs. For example, we observed staff handing out chocolate bars, they gave one to a person who was on a sugar free diet due to their diabetes. Their relative intervened and told them the person could not have the chocolate.

The provider failed to ensure people's nutritional and hydration needs were met. This is a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● The provider was not always working within the principles of the MCA as people had not always been assessed for their capacity to make decisions about their care. People living with dementia were at risk of self-neglect and not being able to make decisions about their care. No provision had been made to assess people's ability to make these decisions and ensure where necessary that decisions would be made in their best interest.
● The registered manager had not recorded if people had a lasting power of attorney (LPA) for their personal welfare in the event of people not being able to make their own decisions. An LPA can make decisions about people's daily routine (washing, dressing, eating), medical care, moving into a care home and life-sustaining medical treatment. It can only be used if people are unable to make their own decisions.
● The registered manager had not worked with other professionals and or an advocate to review peoples' DoLS restrictions to ensure they were least restrictive.
● We observed people being prevented from leaving the home by locks on the doors and staff stopping people from leaving. No one had an authorised DoLS in place.
● The registered manager had previously applied for DoLS for nine people in 2017. These had not yet been assessed by the local authority. The registered manager had not reviewed these DoLS assessments and continued to deprive people's liberty.
● The registered manager did not recognise they were depriving people of their liberty. They had been prompted by the local authority quality monitoring team in March 2019 to review each person's mental capacity and apply for DoLS for people whose freedom was being restricted to keep them safe. The registered manager was in the process of making the DoLS applications; they had made 15 applications so far.

The provider failed to act in accordance with the Mental Capacity Act 2005 to ensure people's deprivation of liberty safeguards were lawful. This is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Need for consent.

Staff support: induction, training, skills and experience:
● The provider did not ensure staff received all the training and supervision they required to carry out their roles. Staff did not recognise when people required support with their meals or know how to accurately record people's care.
● Agency staff did not have the knowledge and skills to provide care for people living with dementia. We observed agency staff unable to communicate with people living with dementia.
● The provider did not ensure all agency staff had an induction.
● Agency staff were not supervised, and their competencies in key areas such as moving and handling had not been assessed.
● All people living at the home were living with dementia. Not all staff had completed training to meet their needs; the registered manager had recently reminded staff to complete training in 'dealing with challenging behaviour' and 'understanding dementia'. Staff were providing care to people with dementia without having the training and skills to provide care that met their needs.
● Although staff received supervision, this was ineffective as staff did not always provide care as they had been trained to do.

The provider did not ensure all staff had the support and training they required to carry out their roles. This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Staffing.

● New permanent staff received an induction to the service and training in the Care Certificate.
● Permanent staff received refresher training in key areas such as moving and handling and fire safety.

Adapting service, design, decoration to meet people's needs:
● People did not have access to all areas of the home designed to enhance their home life. The home had a large communal room which could accommodate people to watch films or take part in crafts. These rooms were being used by staff to have breaks and write up notes. Relatives told us they were willing to take their relatives down to the room to use it, but the registered manager told them, as they had not had the right clearances, they were unable to take other residents with them. The registered manager did not deploy staff to support people to use the area.
● The home was designed to accommodate people living with dementia. There were large open spaces and wide corridors. The rooms were adapted for people to accommodate people's abilities. One relative told us, "It's a nice building, light airy, welcoming, clean and well kept. They have good quality fittings and I particularly like the automatic lights in the bathroom, that reassures me that [name] is ok and won't panic because they can't find the light switch."
● People could easily access communal lounges and the garden.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
● People's needs were assessed before moving into the home. This ensured staff could meet their needs.
● The provider used evidenced based risk assessments.

Supporting people to live healthier lives, access healthcare services and support; staff working with other agencies to provide consistent, effective, timely care:
● Staff worked closely with the local GP who visited the home regularly.
● Records showed relatives were informed of changes in people's health.
● People were supported to attend hospital appointments and access health screening.
● Staff liaised with district nurses, tissue viability nurses, speech and language teams and other health

professionals to ensure people received timely assessments and care.

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

Requires Improvement: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations have not been met.

Ensuring people are well treated and supported; respecting equality and diversity:
- People's experiences depended on whether staff knew them, and how many agency staff were on shift. The provider did not have enough permanent staff to meet people's needs and relied on agency staff for half of all care.
- Agency staff did not always know people well; we saw interactions where agency staff poor communication and actions raised people's anxiety and prevented them from consenting to care. One person told us, "They [agency staff] have difficulty with the language [English], communication is often difficult, they don't understand what we're saying to them and we don't always understand them."
- Staff did not always notice when people were left in wheelchairs for long periods.

Respecting and promoting people's privacy, dignity and independence:
- People's dignity was not always maintained.
- Staff did not notice or support people to receive personal care in a timely way. We observed people with dirty mouths and eyes.
- Relatives told us people's clothes often went missing, only to find other people wearing their relative's clothes. One relative told us, "Sometimes [name] is in mismatched clothes despite leaving outfits already sorted out ready on hangers in their wardrobe. There have been times when [name] has had other people's clothes on and other people have been seen in their clothes." A member of staff had come in on their day off to sort out the laundry and label peoples' clothes. This had been arranged following complaints from relatives.
- Men were not shaved regularly, and ladies' hair was not always brushed. One relative told us, "Sometimes [name's] hair is a mess." Staff wrote in the communications book when people's visitors were due, stating that people would need to be shaved and wear clean clothes. One relative told us they were concerned about their relative's appearance, they said, "I do wonder though how often [name's] having a shower, they needs a good shave too." Another relative told us, "[Name] wasn't dressed properly the other day." Staff did not ensure people's appearance was maintained daily.

The provider did not ensure people were not always treated with dignity and respect. This is a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Dignity and respect.

Supporting people to express their views and be involved in making decisions about their care:
- People were not involved in planning their care.

● People were not supported to access to an advocate.
The provider did not ensure people were involved in their assessment of their needs and preferences. This is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Person-centred care.

● Where permanent staff were providing care, people received compassionate care.
● Permanent staff knew people and had good relationships with them. We observed good interactions and people appeared happy in staff company. Staff played music that people enjoyed and talked about simple things like the flowers on the table.
● One person told us, "These people [staff] are really good, I have mood swings and they really lift me up, we're all friends here." Later when the person became anxious staff showed kindness and took time to distract the person until they appeared less anxious.
● Some staff showed kindness where interactions between staff and residents were caring and supportive. For example, when replacing hand protectors.
● People received their care in a considerate way. For example, by protecting people from the sun or from draughts.
● Staff were vigilant in protecting people from potential conflict. For example, distracting people when their seat had been taken.
● Staff respected people's privacy. People's personal care was carried out in the privacy of their own rooms.
● Staff were discreet when offering people personal care. One relative said, "They do always tell [relative] what they are going to do when moving them or anything else."
● Staff supported people to maintain relationships with their families. Relatives could visit at any time. People told us their relatives visited at different times and were always made to feel welcome.
● People's records were stored securely and staff understood their role in protecting people's personal details.

Inadequate

Is the service responsive?

Our findings

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

Inadequate: Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
● People and their relatives had not always been involved in updating and creating care plans which were not person-centred. Following recent advice from the local authority the registered manager had written to some relatives inviting them to people's reviews.
● People's care plans did not include their life histories, events and people that were important to them. Staff did not have enough information to know what people liked to talk about.
● People's care plans did not always reflect their preferences and cultural needs. Staff did not use information recorded to ensure people received their care in the way they preferred. For example, staff had recorded in the communications book one person preferred specific bedding and requested staff ensured the person had these. However, when we looked at this person's bed they did not have their preferred bedding.
● The registered manager recently introduced people's preferences for male or female care staff following feedback from the local authority in March 2019, before then people frequently received care from staff that did not meet their preference.
People did not always receive their care as planned; this depended upon permanent staff being available.
● Staff did not know how people liked to spend their day and the activities they liked to participate in.
● The service had not looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard (AIS). The AIS is a framework making it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given.
● The provider did not have activity staff employed; they had advertised these posts. Care staff had not been allocated to ensure people were supported to take part in their chosen activities and interests. During the inspection, staff brought some balloons out for people to pat to each other, people seemed to enjoy this. One relative told us, "The activities aren't that inspiring, I have brought things on for them to 'play' with and there could be more of that happening." Another relative said, "My [relative] cannot pursue their artistic interests anymore because of their condition and I feel there aren't enough activities for some of the men. The home's brochure talks of an activities team, the activities lady has left recently."

End of life care and support:
● The registered manager had not ensured people had the opportunity to discuss what was important to them at end of life.
● People had not been assessed for their capacity to be involved in the decision-making process and planning for end of life care.
● Staff had not received training in end of life care. Staff did not always recognise when to call for assistance

from the palliative care team.

The provider failed to ensure people received appropriate care that met their needs and preferences. This is a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Person-centred care.

Improving care quality in response to complaints or concerns:
● People and their relatives did not feel confident their complaints would be listened to. One relative told us, "We don't feel that they [the registered manager] listen to our concerns about [name's] clothing and appearance and dignity."
● The manager did not follow the provider's complaints procedure; they did not respond to verbal complaints or apologise when things had gone wrong.
● The manager had not used information received in complaints to improve the service.

The provider failed to have systems in place to identify, record and respond to complaints. This is a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

- There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
- The provider and registered manager failed to have sufficient oversight of the home and there were failings in all areas of people's care.
- The registered manager did not promote an open and honest culture. When staff did approach management about issues and concerns, these were not managed appropriately. Staff and relatives told us the manager often said they would deal with something but had not done so.
- The provider did not have sufficient systems in place to know which staff were providing care. The rotas did not reflect the staff on duty or the electronic time sheets. We observed staff working who were not on the rotas or booked agency staff.
- The provider and registered manager failed to provide sufficient managerial oversight of agency staff. There were no systems to ensure all the recruitment checks had been made or to monitor agency staff skills and competencies. People received care from staff that did not communicate clearly or carry out safe moving and handling. The registered manager arranged for agency staff profiles to be delivered to the home; but these were not all complete, or for every agency worker.
- The provider did not assess and monitor the effectiveness of the safeguarding and complaints procedures. This had impacted on people's safety as people were not safeguarded from the risks of abuse and could not rely on the service to respond to their concerns.
- The provider failed to have systems in place to assess people for their mental capacity to make decisions about their care or assess people for their need for Deprivation of Liberty Safeguards.
- The provider failed to have systems in place to monitor the support people required at meal times. People had lost weight, the provider failed to identify people were not receiving their fortified meals or assistance to eat their meals.
- The provider failed to have systems in place to ensure people's risk assessments and care plans reflected people's current needs. Staff did not have all the information they required to provide care to meet people's needs.
- The provider's audits failed to identify staff were not following the medicines management policy. Staff failure to record why they gave 'as required' medicines meant people were at risk of having these unnecessarily.
- There was insufficient oversight of the accuracy of people's care records relating to their daily care, health

and behaviours. The fire register and handover records did not match or reflect people's current mobility needs.
● The provider failed to keep accurate records of people who had been admitted to the home, been discharged or had died.
● The provider and registered manager failed to have sufficient systems and processes in place to assess, monitor and evaluate the quality and safety of the care people received. The provider did not have systems to improve the service through continuous learning and re-evaluating.

Working in partnership with others:
● Following concerns raised by relatives and staff in March 2019 the local authority quality monitoring team visited the home. They found multiple issues with the quality of people's care which had not been identified by the provider; they took immediate action to suspend placements to the home. They worked together with the registered manager to implement an action plan to improve safe care and treatment.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
● The registered manager had not shared the outcome of the local authority visit or the action plan with staff. Staff had not been made aware of the changes required to improve the service.
● People and their relatives had been asked for their feedback since September 2018, when relatives stated they were happy with the care provided in the home. Relatives had approached the registered manager to offer their time to plan and carry out activities using existing facilities within the home. The registered manager had not explored the volunteering option but dismissed their suggestions without working out solutions for working together. People did not have any involvement in the running of the home.
● Staff meetings had taken place regularly, however, staff did not have the opportunity to be involved in identifying areas for improvement and implementing new systems.

Continuous learning and improving care:
● The provider did not have systems in place to audit and analyse accidents, incidents, falls or complaints; they did not have the information to learn from these or take steps to improve the service.

The provider failed to have systems and processes to assess monitor and improve the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Good governance.

Statutory notifications:
● The provider failed to notify CQC of thirteen incidents of unexplained injuries since 2 December 2018.
● The provider failed to notify CQC of four incidents of physical/sexual abuse since 14 December 2018.

The provider's failure to notify CQC of incidents which could indicate abuse or improper treatment is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

● The provider failed to notify CQC of 10 deaths since 1 January 2018.

The provider's failure to notify CQC without delay of people's deaths whilst being a resident at the home is a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009. Notification of

death of a service user.

• The provider had displayed their rating from their previous inspection at the service and on their website. People, visitors and those seeking information about the service could be informed of our judgements.

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 16 Registration Regulations 2009 Notification of death of a person who uses services The provider failed to notify CQC without delay of people's deaths whilst being a resident at the home

The enforcement action we took:

Fixed penalty notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC of incidents which could indicate abuse or improper treatment.

The enforcement action we took:

We imposed conditions on the registration to restrict admissions to the home. We also imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people received appropriate care that met their needs and preferences.

The enforcement action we took:

We imposed conditions on the registration to restrict admissions to the home. We also imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure people were not always treated with dignity and respect.

The enforcement action we took:

We imposed conditions on the registration to restrict admissions to the home. We also imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure all people's risks were assessed and staff had information on how to mitigate these risks or have suitable systems in place for the safe management of medicines.

The enforcement action we took:

We imposed conditions on the registration to restrict admissions to the home. We also imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to have suitable systems in place to protect people from potential abuse or improper treatment.

The enforcement action we took:

We imposed conditions on the registration to restrict admissions to the home. We also imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure people's nutritional and hydration needs were met.

The enforcement action we took:

We imposed conditions on the registration to restrict admissions to the home.
We also imposed conditions requiring the provider to supply evidence by 2 July 2019 that
a. all records relating to the monitoring and management of food and fluid intake at The Lakes are completed each day in full detail.
b. Establish and implement an effective system for the review and analysis of daily food and fluid records at The Lakes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints

	The provider failed to have systems in place to identify, record and respond to complaints.

The enforcement action we took:

We imposed conditions on the registration to restrict admissions to the home. We also imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have systems and processes to assess monitor and improve the quality and safety of the service.

The enforcement action we took:

We imposed conditions on the registration to restrict admissions to the home. We also imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure all staff had undergone the relevant recruitment checks and had the skills and competencies to provide safe care.

The enforcement action we took:

We imposed conditions on the registration to restrict admissions to the home. We also imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were enough staff deployed with the right skills and competencies to meet peoples' needs.

The enforcement action we took:

We imposed conditions on the registration to restrict admissions to the home. We also imposed conditions requiring monthly action plans demonstrating how they are to achieve and maintain compliance with the regulations.