Blackcliffe Limited

The Lakes Care Centre

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 16 and 17 February 2015. Following that inspection the service was rated as requires improvement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Lakes Care Centre on our website at www.cqc.org.uk

We undertook this unannounced, focused inspection on 25 and 26 August 2015 because we received some information of concern. These concerns included allegations that inadequate safeguarding procedures were in place that did not protect people living at The Lakes Care Centre. That inadequate complaints procedures were in place which did not support staff to learn from people's experiences, concerns and complaints.

Prior to this inspection Tameside's safeguarding adults team had looked at how the home had investigated an allegation of physical abuse that involved a person using the service. Following their investigation some recommendations had been made to the service as to how they could improve their investigation procedures.

The Lakes Care Centre is a care home for up to 77 elderly people who require personal or nursing care. It has a

Summary of findings

residential unit known as The Kendall Suite, with 15 beds, a nursing unit, known as The Derwent Suite with 37 beds and a specialist dementia care unit, known as The Coniston Suite, which had 25 beds. It is situated in a quiet location in its own grounds in Dukinfield, close to public transport links.

Accommodation comprises of all single rooms some of which have en-suite facilities. Each suite had a communal lounge and dining room and access to a safe, enclosed outdoor space.

There was a registered manager in post although they were not present during this inspection. 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.

We saw there were sufficient numbers of staff working in the home to meet people's needs and staff spoken with confirmed this.

We saw that the Coniston and Kendal suites were not visibly clean and there were no detailed cleaning schedules in place to indicate exactly what cleaning had been undertaken.

We saw that there were no systems in place to analyse safeguarding incidents to identify triggers or evidence of action taken to look at minimising the risk of reoccurrence of incidents.

There were systems in place to record complaints however they were not robust or detailed.

There was a lack of robust systems in place to monitor the quality of service people received and this had resulted in many of the shortfalls and breaches of regulations we found during the inspection process.

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Systems were not in place to effectively analyse safeguarding incidents or actions taken to minimise the risk of reoccurrence of incidents.

During our inspection visit we saw that some areas of the home were not visibly clean.

We saw there were sufficient numbers of staff working in the home to meet people's needs.

Requires improvement 

Is the service effective?

Is the service caring?

Is the service responsive?
The service was not always responsive.

Robust systems were not in place to demonstrate that all complaints made had been acknowledged, thoroughly investigated, the actions taken and monitored over time to look for trends and areas of risk that may be addressed.

Requires improvement 

Is the service well-led?
Some aspects of the service were not well-led.

There were no clear lines of accountability of who had overall responsibility for the home in the absence of the registered manager and/or the provider.

There were not robust systems in place to monitor the quality of service provided in relation to the cleanliness of the home, complaints made and safeguarding investigations.

Requires improvement 

The Lakes Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 26 August 2015 and day one was unannounced.

The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During this inspection we spent time in the home observing care and support being delivered to people in the communal areas on the Coniston and Kendal suites and checking the environment and levels of cleanliness on these suites. We looked at a range of records relating to the safeguarding and complaints procedures including the records of complaints made and records relating to staffing levels in the home.

During the inspection we spoke with five people who used the service, four visitors, two senior care staff, two care workers, one registered nurse, the unit manager from The Coniston Suite, the deputy manager from The Kendal Suite and the administrator.

Requires improvement

Is the service safe?

Our findings

During this inspection we received mixed responses about the service when we spoke with people living at The Lakes Care Centre and visitors. One person on The Coniston Suite said "The staff look after you and [the person] never had any trouble." However a person living on The Kendal Suite told us that "Things could be better." They said that staff could be rude if they thought you were complaining. Another person told us "I don't get enough attention from staff and they don't talk to me."

Some of the comments received from visitors included : [their relative] "Is well cared for physically and the staff are very caring and kind to her," "It's ok, it seems alright and the staff are good" and "I love everything about this home, it runs very well and there are no problems or concerns." Another visitor told us they thought the home was "satisfactory" and the physical care was "good" but they thought there should be more mental stimulation for the people living there.

We were shown a copy of a local authority safeguarding adult's policy. However the staff we spoke with on The Derwent Suite told us they were unsure how to access this policy.

One senior member of staff we spoke with on The Coniston Suite was able to describe the internal process for dealing with safeguarding concerns but other senior members of staff were unable to. This meant that not all staff had a clear understanding of their individual responsibilities to prevent, identify and report abuse when providing care and treatment.

We looked at the training records which indicated all staff had received safeguarding adults training. However one member of staff we spoke with told us they had not undertaken the training and when we looked their name was not included on the training record. This meant there was no up to date safeguarding adults training record.

We were told and saw evidence that all new members of staff were given a short in house presentation on basic safeguarding awareness and this was complemented by attending local authority safeguarding training.

The staff we spoke with were able to demonstrate a good understanding of what may constitute a safeguarding issue. However, they said that whilst they would report untoward incidents they had no responsibility for dealing with the issues. One member of staff told us that she "does not deal with safeguarding." This meant that staff did not fully understand that safeguarding vulnerable people is the responsibility of everybody employed at the home.

The people living on The Coniston Suite had a diagnosis of Dementia which means that they can sometimes exhibit behaviour that challenges the service. We saw staff were vigilant in their observations of people. For example, we witnessed a good response to de-escalate an incident which may have had serious consequences. In this incident staff were able to recognise the dangers and calmly dealt with the situation, ensuring that both people involved were separated, appropriately reassured, checked and made safe. However we also saw an incident on The Kendal Suite where staff were slow to respond to an incident between two people living on that suite which had the potential to put the person at risk.

From speaking to staff and from our observations we found there were no consistent procedures in place for recording safeguarding incidents. We saw there was an incident file where incidents were logged, but various different forms were used. For example relevant information recording charts, incident forms, body maps, and a form titled 'challenging behaviour'. This meant that there was a lack of consistency in the documentation used for the recording of incidents. In addition when we cross referenced a recorded incident in the file to the persons care file we found there was no reference in the care file to the incident that had occurred. This meant that documentation was not detailed appropriately and the lack of accurate recording could have the potential to put the person at risk.

There was no recognised procedure in place to determine when incidents should trigger a safeguarding alert to the local authority. Whilst staff were vigilant and aware of people's needs, incidents were taken in isolation. There was no analysis to determine triggers which may have led to the incident, nor was there any action taken to look at minimising the risk of reoccurrence. For example, on the incident forms we looked at there was a section asking for 'steps taken to minimise reoccurrence'. We reviewed 10 forms and in all but one this section was left blank. This meant that people remained at risk of harm.

We reviewed a safeguarding incident which had been investigated internally by the provider within the parameters of the local authority multi agency policy. This

investigation did not take into consideration the previous behaviour patterns of the perpetrator. There had been at least seven prior incidents where people had been put at risk by the behaviour of the perpetrator, but these had not been taken into consideration within the safeguarding investigation. Had the perpetrator's behaviour pattern been monitored and an earlier intervention taken place, in response to this person's behaviour, risk to the other person and people living on this suite may have been minimised.

The above examples demonstrate a breach of regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we undertook a tour of the home including some bedrooms, toilets and bathrooms on The Coniston Suite and The Kendal Suite and spent some time in the communal areas.

On The Coniston Suite and The Kendal Suite we saw shortfalls in the cleanliness of the units. For example, in both of the dining rooms we saw encrusted food on the dining room chairs, the two metal drinks serving trolleys on The Kendal Suite and one trolley on The Coniston Suite were dirty with spilt drinks and encrusted food, the curtains in the dining room on The Coniston Suite were stained and marked as well as the wall and radiator. On the Kendal Suite the over chair tables we looked at had encrusted food on the rims of the tables.

We saw the hoists and some wheelchairs on both The Coniston Suite and Kendal Suite were dirty as was a hoist sling draped over the hoist on The Kendal Suite. Some of the chairs on the corridor on The Coniston Suite and some chairs in people's bedrooms on both units were stained and marked. Such poor levels of hygiene meant that people were not receiving care and treatment in a clean environment.

The above examples demonstrate a breach of regulation 15 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We viewed the Jacuzzi bathroom on the The Coniston Suite and found a number of inappropriate items being stored. We saw two raised toilet seats, a linen bag metal frame, a shower chair, a catheter stand and a dirty walking frame. This room was not locked and could therefore be accessible to people who used the service and could place people at risk of falls or entrapment due to the inappropriate items being stored within this room. We also saw personal toiletries and there were brown stains on the base and edge of the bath. We saw a bar of soap, a sponge and a bottle of shower gel. We found an open and half used pot of prescribed cream dated January 2015. When we asked why the cream had been left in the bathroom the unit manager told us that the person the cream had been prescribed for had not lived at the home since April 2015. The unit manager made assurances that the personal toiletries would be removed immediately and the bath cleaned.

The above examples demonstrate a breach of Regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the staffing rotas for the previous four week period and how the service was being staffed. We did this to make sure there was enough staff on duty to meet people's needs. All of the staff who we asked told us they thought there were sufficient numbers of staff to safety meet people's needs. During the inspection although the staff were busy we saw that people who required assistance were responded to in a timely way and did not have to wait long. Staff were seen during the inspection in sufficient numbers to provide supervision and meet people's needs.

Is the service effective?

Our findings

Is the service caring?

Our findings

Requires improvement

Is the service responsive?

Our findings

At our last inspection of the service in February 2015 we found that care records and other documentation was not being updated with appropriate information to make sure people received treatment and care that met their individual assessed needs. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance. These breaches were not looked at during this unannounced, focused inspection.

We asked the staff on The Kendal Suite how they informed people of how to make a complaint. Initially we were told that if people wanted to make a complaint they would just come to the office and make their complaint.

When we inspected the service in February 2015 we looked at how complaints were managed and found no concerns. However, since our last inspection of the service, the complaints policy had become out of date as it still contained the name of a unit manager that had left the service 12 months ago and it still contained the name previously used by the registered manager. We were given a 'handling complaints and compliments policy' from a folder in the office which was dated 23 July 2001. The member of staff said she thought there might be a more up to date policy but was unsure where it was. This meant that the staff did not have up to date information in how to respond if somebody wanted to make a complaint.

We looked in the 'complaint book' at a complaint made by a relative in May 2015. The action taken was recorded that a note was to be left in the communication book and monitor closely. We saw that a note had been left in the communication book but the person's care plan had not been updated accordingly and there was no evidence that any monitoring had taken place. This meant that it was not clear if the complaint had been responded to.

We looked at the complaint records on both the Coniston and Kendal Suites. The records did not include evidence that complaints made had been acknowledged or thoroughly investigated. We were told that one of the complaints had been referred to Tameside's adult safeguarding team and that information was kept in the desk drawer. However this had not been documented in the complaint records. Action taken to resolve a complaint made by a relative in May 2015 was identified by a note left in the communication book and to monitor closely. We saw that a note had been left in the communication book but the person's care plan had not been updated to reflect this information and there was no evidence that any monitoring had taken place. This meant that it was not clear if the complaint had been responded to or satisfactorily resolved.

We saw that some inappropriate entries had been made in the complaints records seen. For example, records had been made of people's death and some information related to personal care. Some of the information was vague and did not include details of the actual complaint being made. For example, one entry was that a complaint had been made by a resident but it did not include the person's name. Another entry stated that the complaint was made by a resident's daughter but there were no details of the daughter's name and the care plan for the resident had not been updated.

We found no analysis of complaints had been completed to identify any themes or ensure appropriate action had been taken to resolve the complaint and improve service provision.

Lack of an effective system to receive, record, monitor and investigate complaints thoroughly meant that people using the service and others who may wish to raise a complaint could not be confident that their complaint(s) would be dealt with to their satisfaction.

The above examples demonstrate a breach of Regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Our findings

At the time of this inspection visit there was a registered manager in post.

On the two days of our inspection the registered manager and the provider were unavailable. We were told there was no designated person taking overall responsibility for the service. We were told that each suite had an identified person in charge shift by shift. This meant there was no management and clear lines of accountability for the service as a whole.

Prior to this inspection visit the Care Quality Commission (CQC) identified that the registered manager had not been sending in all the required statutory notifications relating to abuse or an allegation of abuse in relation to a service user. This was discussed with the registered manager prior to the inspection and with staff during this inspection who told us that it had been the responsibility of the unit managers to inform CQC. Under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4) states that the registered person must notify the Commission. Prior to the inspection the registered manager informed us she had taken steps to assume the responsibility of sending these statutory notifications to CQC.

We asked the unit manager from The Coniston Suite and the administrator to tell us how they monitored and reviewed the quality of the service in relation to the cleanliness of the home. We were told that there was no formal process to check or audit the ongoing cleanliness of the home. The was a generic cleaning schedule which simply outlined the timeframes for cleaning but there was no evidence of what cleaning had been undertaken and when.

We asked how the service monitored complaints made over time looking for trends and areas of risk and how lessons were learnt from the outcome of complaint investigations. We were told that the registered manager had started to analyse the complaints made on The Coniston Suite. However we saw the information recorded on the 'analysis' paperwork was a copy of the notes taken from the complaint records kept on the suite. The unit manager from The Coniston Suite confirmed that she had completed the analysis sheet and passed it to the registered manager. The registered manager had then signed to evidence she had seen the information. We did not see evidence of systems in place to ensure all complaints made about the service had been reviewed, lessons learnt and areas of risk identified and addressed.

We saw that the recording systems currently in place did not analyse patterns or trends relating to safeguarding incidents or include action taken to look at minimising risk of reoccurrence. This meant that people could be at risk of escalating or reoccurring safeguarding incidents.

We found that there was no structured audit process in place in relation to safeguarding incidents, complaints and the cleanliness of the home. This had resulted in the shortfalls and breaches of regulations we found during the inspection process.

The lack of robust systems being in place to monitor the quality of service people received demonstrates a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

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 **Systems and processes were not effectively implemented to prevent the risk of abuse to people.** **Regulation 13 (1) (2) (3)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Systems and processes were not effectively implemented to prevent the risk of abuse to people.** **Regulation 13 (1) (2) (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Some areas of the service were not clean.** **Regulation 15 (1) (a)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Some areas of the service were not clean.** **Regulation 15 (1) (a)**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with unsafe or unsuitable because parts of the premises were being used inappropriately and not for the intended purpose. Regulation 12 (2) (d)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with unsafe or unsuitable because parts of the premises were being used inappropriately and not for the intended purpose. Regulation 12 (2) (d)

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 did not have robust systems in place to respond and monitor complaints made over time to looking for trends and areas of risk that may be addressed. Regulation 16 (1) (2)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not have robust systems in place to respond and monitor complaints made over time to looking for trends and areas of risk that may be addressed.

This section is primarily information for the provider

Action we have told the provider to take

	Regulation 16 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have a sufficient and effective system in place to regularly assess and monitor the quality of service that people received. Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have a sufficient and effective system in place to regularly assess and monitor the quality of service that people received. Regulation 17 (1) (2) (a) (b)