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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

The Lakes Care Centre is registered with the Care Quality Commission to provide nursing and residential care for up to 77 older people. There are three Suites, the Derwent, the Kendal and the Coniston Suites. The Derwent Suite provides nursing care for up to 37 people. The Kendal Suite provides residential care for up to 15 people and The Coniston Suite provides care for up to 25 people with dementia related needs.

This inspection took place on 19 October 2017 and was unannounced.

This inspection was prompted by receipt of a Regulation 28 Coroner's Report received on the ninth October 2017 informing of an incident that took place on 24 May 2017 following which a person using the service later died in hospital. Regulation 28 reports are issued by Coroners when the Coroner remains concerned that similar incidents could reoccur.

Information shared with the Care Quality Commission about the incident indicated potential concerns about the management or risk of falls and the subsequent investigation of falls by the registered provider.

The concerns raised form part of the two domains; is the service safe and is the service well led. Our findings are reported under these domains.

You can read the report form our last comprehensive inspection, by selecting the 'all reports' link for 'The Lakes Care Centre' on our website at www.cqc.org.uk.

At the time of our inspection, 74 people were using the service, 36 on the Derwent Suite, and 14 on the Kendal Suite and 24 on the Coniston Suite.

There was a registered manager in place and they were available throughout 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.

Care records, risk assessments and systems were in place to help and support staff to minimise the risk to people of having falls.

Staff had received the moving and handling training they needed to help make sure people were supported safely when mobilising.

During this inspection we found two breaches of regulation. These breaches related to none notification to the Care Quality Commission of the serious injury of a person who used the service and action had yet to

take place to minimise the risk of falls to people using the service, especially at mealtimes.

You can see what action we have told the provider to take at the back of the report. We are currently considering our options in relation to enforcement in relation to some breaches of regulations identified. We will update the section at the back of the inspection report once any enforcement work has concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People using the service were still at risk of falls, especially at mealtimes until the new mealtime protocol had been put in place and was operational.

Staff had received moving and handling training to help make sure they maintain safe practice.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The Care Quality Commission had not always received the required notifications of incidents involving people who used the service.

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 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.

This focused inspection took place on 19 October 2017 and was unannounced. One adult social care inspector undertook this inspection.

The inspection was prompted in by receipt of a Regulation 28 Coroner's Report informing us of an incident following which a person using the service later died.

At the time of the inspection there were 74 people receiving a service from The Lakes Care Centre. We spoke with the person in charge on arrival and with the registered manager, who is also the nominated individual along with the registered provider for the service. We also spoke with the deputy unit manager and two care workers on The Coniston Suite and the unit manager and senior care worker on The Kendal Suite.

We looked at the care records of four people, the services staff training matrix and reviewed the policy and procedures for falls risk management.

Requires Improvement

Is the service safe?

Our findings

We looked at what action the registered provider took to ensure that staff providing care or treatment to people who used the service had the qualifications, experience, skills and competence to do so safely when assisting people with their mobility needs. The processes in place to monitor people at risk of falls and the action that would be taken should a person suffer a fall.

Records were held in care plan files of those people at risk of falls. We looked at the care plans of four people, some of whom required the use of a hoist or other equipment such as a walking aid when being assisted to mobilise. Each file included a risk assessment detailing the support the staff would need to provide to minimise the risk to the person of having a potential fall. We looked at this information to check whether all reasonably practical action was being undertaken to minimise any risks and how this information was recorded and shared by the staff teams. A care plan is written information that sets out a person's care and support needs and how they will be met. A risk assessment is written information about how a person's health, safety and welfare will be managed and known risks be mitigated.

Care plans seen identified those people who had received support from other healthcare professionals such as a physiotherapist to help them maintain their mobility and reduce risk of falls.

We saw that staff had received training in moving and handling and the registered manager confirmed that this training would be updated to include particular reference to monitoring people safely to minimise the risk of falls. A new falls and prevention management policy document had been put in place which clearly stated that all new admissions to the care centre must be assessed on admission for potential risk of falls. Following which, preventative approaches are to be initiated and appropriate interventions identified, when required. Staff we spoke with during the inspection confirmed that meetings had been held where this information had been shared with them.

A review of how people were supported at significant times of the day for example, when people were getting up and when they were retiring to bed, had been undertaken to ensure that at such times, people at risk of falls were monitored by nursing and care staff at all times. This especially related to mealtimes when people were accessing dining areas. The registered manager had held a meeting with staff on 17 October 2017 where the decision had been taken to change how the meal times were to be operated to ensure people were supported safely with the maximum number of staff being available to assist. The registered manager had introduced two sittings each mealtime. The first sitting would enable staff to assist people who required support in bed safely whilst other staff monitored lounge areas. The second sitting would enable the maximum number of staff to be available in the dining areas to monitor and assist people, especially those at risk of falls.

The new mealtime protocol had yet to be initiated and, therefore people were still at risk.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The registered manager had developed a new falls prevention and management protocol. The protocol clearly outlines the action to be taken should a person using the service suffer a fall. Providing staff with guidance in relation to what action they need to take to ensure the safety of people and that the right care and treatment is provided.

The falls prevention and management protocol requires the unit manager to complete a 'matrons report' giving all relevant details of the fall and any actions taken following the completion of the post falls assessment. The registered manager told us that all this information could then be gathered and used to investigate the circumstances surrounding the fall. Again, staff spoken with confirmed they had been informed that this document had to be completed and provided immediately to the registered manager or as soon as possible after the incident.

We saw when an accident or incident had occurred, appropriate documentation had been completed by managers or staff in charge. Evidence was available to demonstrate that all falls, accidents and incidents and actions taken, were brought to the attention of the registered manager on a daily basis using the 'matrons report'.

Since the incident on 24 May 2017, a review had taken place of those people at the greatest risk of falling. The registered manager had ensured that this information had been shared with all staff via staff meetings and one to one supervisions with senior staff.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

On our arrival at The Lakes Care Centre, we saw that the last inspection report rating for the service was prominently displayed in the reception area of the home, where people visiting the service could see it. We also checked the providers' website on 16 October 2017 and found that the latest rating was being displayed on the front page, including how to access the services latest report.

Because the service had received a Regulation 28 report from Her Majesty's Coroner, we checked our records to see if we had been notified of the details of the incident that lead to the report. The registered manager and/or registered provider must notify the Care Quality Commission (CQC) in a timely way of any serious injury sustained by a person using the service or the death of a person using the service. Such matters must be notified to the CQC using a Statutory Notification form that is accessible via the CQC website.

Our analysis of the Statutory Notifications received from the service indicated that the service failed to report the incident which resulted in serious injury and contributed to the person's death. This matter was only mentioned in an expected death notification two weeks later. In our discussions with the registered manager about this it was confirmed that they understood their responsibility to ensure such matters are always reported to CQC in a timely way and using the appropriate documentation. They also stated they would ensure all senior staff understood their role to report such matters in the absence of the registered manager.

The failure to submit notifications as required is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager told us that since receipt of the report from the coroner a lot of work had been undertaken with staff teams to minimise the risk of such an incident occurring again. In our discussion with the staff they told us they had been informed about the incident and subsequent coroner's report via staff meetings. They also told us they had been informed of the importance of accurate recording of the new falls protocol documentation relating to the care and wellbeing of people living in the home. They also confirmed they had been told about the new dining routine that was to be implemented.

We looked at what action the registered provider and registered manager had taken to help prevent the type of incident which prompted this inspection from happening again. Both the registered provider and registered manager had held meetings with the nurses and senior staff to inform them of the new protocol and their roles and responsibilities to ensure they clearly understood the importance of keeping people safe.

New documentation had been introduced as part of the falls prevention and management protocol. A checklist has been introduced in order that staff can 'check off' actions taken, including carrying out hourly observations following a fall if the person is not transferred to hospital. A Post Fall – Assessment Check List had also been introduced. The information required to be completed covered five particular areas, level of the persons consciousness, pain/discomfort, injury/wounds, observations before moving if injury suspected and mobility. Staff had to complete a response to each question by selecting an option provided, for example, is the person responsive (verbal/other), less responsive that usual, or unresponsive/unconscious (call 999). A body map also had to be completed.

As part of the new protocol, following any fall by a person using the service, the unit manager had the responsibility of making sure the 'matrons report' was completed giving all relevant details of the fall and any actions taken following the completion of the post falls assessment. The registered manager told us that all this information could then be gathered and used to investigate the circumstances surrounding the fall. Again, staff spoken with confirmed they had been informed that this document had to be completed and provided immediately to the registered manager or as soon as possible after the incident.

Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. We saw evidence to demonstrate that, since the incident on 24 May 2017 the registered manager and senior staff had contacted people, for example, next of kin and named representatives when a safety incident had occurred to a person using the service. We further discussed this matter with the registered manager to ensure they had a clear understanding of their duty and that of the registered provider in relation to Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Duty of candour.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify us of a fall, which had resulted in a serious injury significantly affecting the health of the person concerned. Regulation 18 (1) (2) (a) (ii) (b) (i) (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of falls; especially at mealtimes until the new mealtime protocol was put in place and was operational. Regulation 12 (1) (2) (a) (b)