The Orders Of St. John Care Trust

The Lakes Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 8 and 9 February 2018 and was unannounced. It was the service's first inspection since registering with the Care Quality Commission (CQC) in March 2017.

The Lakes Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home can accommodate 64 people across four separate units, each of which have separate adapted facilities. At the time of the inspection 23 people lived in two units (two further units were not yet used). The home specialises in meeting the needs of those who live with dementia but also meets people's physical health needs.

Accommodation for people comprised of single bedrooms with private toilet and washing facilities. All bedrooms were provided with bedroom furniture, a window and heating. Each unit, called a household, had its own dining and kitchen area with communal lounges. Additional toilets and adapted bathrooms were also available on each unit. On the ground floor another communal area was used for activities. This was also the home's in-house tea/coffee room.

There was not a registered manager in position. A newly appointed home manager was however in post and they had started the application process to be the registered manager of the home. 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 home had lacked consistent management and effective leadership for some time. Challenges from this had arisen, which the new managers had a good understanding of and were addressing. At the time of this inspection the home was being well-led and strong leadership was being provided. On-going quality monitoring of the services provided was in place and from this identifiable improvements had already taken place. The new managers were in control of the service and a more robust management structure was emerging. Clear lines of delegation, responsibility and accountability were being established throughout the staff team. These improvements needed to be sustained for the rating of is the service well-led? and the overall rating of the service to alter from requires improvement to a rating of good.

Feedback had been previously given by relatives and staff regarding the issues arising from inconsistent management of the home. New managers had sought further feedback since being in post. They had taken this into consideration when making necessary changes to improve the service. A significant decision had been made by the provider to no longer admit people who had been assessed as requiring nursing care. This was so staff could ensure people's needs were met. It was confirmed during the inspection that there was no one living at the home with nursing needs. A supportive approach was being taken by managers to help some staff adjust to the new ways of working. People spoken with [apart from one] told us the changes

were making the home a better place to live in. All relatives spoken with told us they felt reassured by the new management arrangements and the changes managers were making.

People's needs had been assessed before their admission to The Lakes Care Centre and subsequently. There were arrangements in place to keep people safe and to protect them from harm. For example, improvements had been made to how people's medicines were managed and how people's risks were assessed and managed. This had resulted in safer medicine administration practice and a subsequent reduction in medicine errors. It had also resulted in risks to people being correctly assessed and managed. People were protected from potential abuse because staff knew how to recognise this and report any concerns they may have. People were supported to maintain their nutritional well-being and the new chef was providing people with a good choice of food.

The principles of the Mental Capacity Act were being followed. People were supported to have maximum choice and control of their lives and where support was needed, this was in the least restrictive way possible. The policies and systems in the home supported this practice. Adaptations had been made to the environment, to support people's mental and physical needs, and to help retain their independence.

Action was being taken to ensure all staff completed the provider's necessary training and that they received the support they needed to ensure best practice. Some staff had acquired new roles and needed further professional development to fulfil these effectively. Despite some training having not been completed, staff did not lack knowledge and skills they needed to support people. Some alternative support had been provided to improve staff practice and further support and training was planned. Safe staffing numbers had been maintained by the new managers to ensure people received the care and attention they needed. Additional staff had been appropriately recruited and further staff recruitment was planned to support the home moving forward. There were on-going arrangements in place to keep the home clean and well maintained.

Care was provided in a kind and compassionate way. People and their relatives (where appropriate) were involved in planning the care delivered to them. Staff took into consideration their wishes and preferences and tailored people's care around these. Staff showed an interest in supporting people to live well with dementia. This was particularly seen when supporting people to feel included and when helping them to take part in social activities. People's dignity and privacy was upheld. Relatives and friends were made to feel welcome.

There were arrangements in place for people to raise complaints or areas of dissatisfaction. In the past some of these had not been satisfactorily resolved so new managers had focused on making sure these were resolved where at all possible. People's end of life wishes were explored with them and there were staff, experienced in this care, to provide this when it was needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received support to take their medicines safely and as prescribed.

Risks to people's health and their safety were identified and actions taken to reduce these.

There were enough staff to ensure people's needs were met. Safe staff recruitment processes helped to protect people from those who may not be suitable.

Actions were taken to protect people from potential abuse and discrimination.

People lived in a clean home where infection control measures were in place and where actions were taken to avoid potential risks.

Is the service effective?

Good

The service was effective.

Arrangements were in place to ensure staff completed necessary training. They were receiving the support they needed to professionally develop and for best practice to be established.

People's needs were assessed on admission and thereafter to ensure they continued to receive the right level of support.

People were supported to make independent decisions. The principles of the Mental Capacity Act were adhered to and this protected those who lacked mental capacity.

People had access to health and social care professional as needed.

People's nutritional wellbeing was supported and risks related to this identified and managed.

Adaptions had been made to the environment to meet people's

diverse needs.

Is the service caring?

Good

The service was caring.

People's care was delivered with kindness and compassion.

Staff knew the people they cared for well and delivered their care around their preferences, likes, dislikes and diverse needs.

Relatives received support and were made to feel welcomed when they visited.

People's dignity and privacy was maintained. Information held about people was kept secure and confidential.

Is the service responsive?

Good

The service was responsive.

People and relatives had opportunities to be involved in planning the care which was delivered.

People were supported to take part in activities they enjoyed and which had a therapeutic value.

There were arrangements for complaints and areas of dissatisfaction to be raised, listened to and addressed.

People's end of life wishes were explored with them in order to ensure these could be met at the appropriate time.

Is the service well-led?

Requires Improvement

The service was well-led but the improvements made needed to be sustained and further developed.

People had benefited from there being strong and consistent leadership in place with values which supported their wellbeing.

Staff were being provided with support whilst positive changes to how the service ran were being made.

The provider's quality monitoring arrangements helped to identify shortfalls and were now being used to make effective improvements.

People were supported to use the wider community but further

links with community based groups were planned.

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.

Inspection site visit activity started on 8 February 2018 and ended on 9 February 2018.

The inspection was carried out because the home's first inspection was due. It was also in response to information of concern received about the home. The information shared with the Care Quality Commission (CQC) indicated there were concerns with: how risks to people were managed, with staffing numbers and the overall management of the home. The provider had already let the CQC know of several changes in the management of the home since May 2017.

One inspector and an expert-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case a person with expertise and experience of working with looking after people who lived with dementia.

Before the site visit we reviewed the information we held about the service. This included the information of concern as well as all statutory notifications. The provider, by law, must inform the CQC of certain significant events, which have an impact on people. A Provider Information Return (PIR) was not requested prior to this inspection. A PIR is a form which gives some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we spoke with five people who lived at The Lakes Care Centre and four relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the five care staff, the chef, an activities co-ordinator, the deputy manager, the newly appointed home manager and the interim manager. We also spoke with the maintenance person, the provider's area property surveyor, an operations manager and the provider's area operations director. We spoke with one visiting healthcare practitioner.

We reviewed the care records of three people. These included risk assessments and care plans. We reviewed records relating to the Mental Capacity Act for nine people. We reviewed three staff recruitment files, the home's staff training record and competency records for all staff who administered medicines. We reviewed records relating to complaints received by the home. We reviewed recorded call bell response times. We reviewed the home's clinical risk register, which included up to date information on risks relating to: nutrition and loss of weight, falls and pressure ulcer development. We reviewed medicine audits and a selection of other audits which included the infection control audit. We reviewed all maintenance records and were provided with copies of all service checks carried out by specialised contractors. We reviewed the minutes of some meetings held with staff.

Good

Is the service safe?

Our findings

Information received by the Care Quality Commission, prior to the inspection, indicated people may not be safe. The concerns reported included: multiple medicine errors, a high number of falls taking place and risks associated with these not being appropriately managed. A lack of staff to meet people's needs and infections not being managed or reported properly.

We found there were arrangements in place to ensure people were kept safe. The management of medicines had been reviewed by one of the new managers when they had arrived. They had found that medicine errors had occurred. They had also found that best practice in the administration of medicines, along with some of the provider's safety checks, had not always been followed.

They had first checked to see if all staff who administered medicines had completed relevant training; they found they had. They also reviewed when staffs' competencies in medicine administration had last been checked. We also reviewed the staff training record as well as staff competency records. We found training had taken place and staff competencies in medicine administration had been reviewed in 2017. Following a medicine error, in June 2017, managers at the time, had held a staff meeting to reflect on the circumstances of the error and to identify areas for learning. Identified medicine errors had included incorrect doses, missed doses and poor completion of relevant records. When errors had happened, these had been reported to the person's GP who had checked the person's health.

The new manager had identified continued poor practice in the maintenance of people's medicine administration records (MARs). When staff did not correctly complete the necessary records, the provider classified this as a medicine error. This is because the poor maintenance of MARs potentially puts people at risk of further medicine errors.

A full review of the medicine system had followed and changes were made to ensure best practice was followed. For example, staff had to check people's MARs before they began administering medicines and other various best practice and safety measures were introduced. The manager began to frequently monitor the MARs as well as other relevant records and staff practice. A training workshop, in safe administration and record keeping, was held to support best practice and improve staff knowledge. The frequent monitoring measures were still in place at the time of the inspection. The manager was able to confirm there had been no further missed or incorrect doses. There had also been no further errors found on people's MARs for the two weeks leading up to this inspection. The manager told us they were confident that staff practice had improved and people were receiving their medicines safely and as prescribed. The close monitoring processes were to continue.

Staff were aware of their responsibilities to ensure people who lived with dementia, received adequate pain control. We observed one member of staff ask one person, several times, if they were in pain. The member of staff had read the person's body language, which we had also observed and which suggested they may well be in pain. We also spoke with a member of staff responsible for administering medicines. They had a more in-depth knowledge of the person's pain control medicines. They told us the person had refused one of the

pain control medicines [which was in tablet form] at the last medicine round. Staff had therefore been monitoring the person more closely for signs of pain. Staff told us they were going to review the person's medicines with the GP. This was because the person had refused their tablets before and staff wanted the GP to consider prescribing the medicine in liquid form instead. Staff told us they felt the person may find this easier to accept and swallow.

The new managers had started a clinical risk register and they held weekly risk governance meetings. During these meetings all risks to people's health were reviewed and discussed to ensure appropriate action was taken to address these. Risks relating to falls were included in this. The managers had reviewed previous accident records and had found that incidents, which they considered not to be 'falls' had been recorded as such. They told us this had made the number of falls occurring at The Lakes Care Centre appear high. The managers told us it had been important to clearly distinguish between a 'fall' and other incidents. This was because they wanted to ensure that for each 'fall' and for each other incident, the most appropriate action had subsequently been taken.

The managers explained that following a 'fall' they would expect the already completed falls risk assessment, to be reviewed. Other actions may then include, a review, by a GP of the person's physical and mental health. This may lead to a review or adjustment of the person's medicines. The person's eye sight and condition of their feet may also require review. A referral to other specialists maybe required, such as a Parkinson's Disease practitioner or the falls clinic. A review of the environment, equipment used and footwear maybe also need to take place. Other incidents, for example, where precautions had already been taken to reduce risks to people, required different actions to ensure the person continued to remain as safe as possible. For example, in the case of a person rolling off their specialised lowered bed onto a padded mat alongside the bed. In this case, the actions to reduce injury to a person had already been taken. However, a review of whether these remained the best options for that individual needed to happen and adjustments made where needed.

We reviewed the care records of two people who were on the risk register and who had been assessed as a high falls risk. The relevant records for one person showed the risk level increased when necessary changes were made to their medicines. The person's relevant care plan made reference to this and made staff aware of the increased risk and the level of support they needed to provide. The second person was at risk of falling because they were physically and mentally unable to anticipate or assess personal risk. The reasons for both these people's potential to fall had been clearly recorded, as had the actions for staff to take to support them. We spoke with two staff about these people's falls risks. They were fully aware of the levels of risk, the reasons which may cause these people to fall and what they needed to do to reduce the possibility of that happening. They gave us examples of how they did this. Later in the day we observed a third member of staff closely monitoring one of these people, from a non-intrusive distance, to ensure they walked around the lounge safely.

Other risks to people's health, such as the development of pressure ulcers, were identified and assessed. A pressure ulcer risk assessment tool was used to identify levels of risk. These were completed monthly and any changes in a person's skin condition identified. Where people's health or their skin indicated they may be at risk of developing a pressure ulcer, pressure reducing equipment, such as mattresses and cushions were put in place. The arrangements for obtaining this equipment and the on-going assessment of this risk would alter moving forward. Staff would need to liaise with community nursing staff, with regard to pressure ulcer risk and management, now the home no longer employed its own nurses.

Staff numbers, along with people's needs and expectations, were being monitored to ensure these could be met. One relative told us they had previously considered moving their relative because, "There were times

when they [staff] were just too thin on the ground." They however, referred to things as having improved in this respect since the new managers had been in post. Some people commented, in the past, there had been staff shortages and a heavy reliance on agency staff. Three people told us they had previously waited a long time (fifteen or twenty minutes) for their call bell to be answered. However, those who were able to continue talking with us about this, now felt staffing levels were adequate. They also confirmed their call bells were generally answered promptly.

Staff who spoke with us about staffing levels told us these were usually adequate and generally allowed them enough time to spend with people. One member of staff told us there had been a struggle to meet people's needs in the past, but this had improved. Two other members of staff told us they felt there was still "room for improvement" in how staffing teams organised their work. A new early morning breakfast routine was being tried out to look at this. The new managers wanted to ensure, there were enough staff to provide personalised care and meet people's particular preferences. We observed people's needs being met in an un-rushed manner at meal-times and at other times of the day. We observed staff checking people to ensure they were safe and spending time with those who needed additional reassurance and supervision. Staff also took time to support people's individual preferences, such as having a cigarette and a chat outside.

Staff recruitment records showed that appropriate checks had been completed before staff started work. This included the six volunteers who visited the home and whose recruitment checks were organised and completed by the provider. This protected people from those who may not be suitable. There had been and continued to be new staff recruited. The managers told us this was needed to ensure there were enough staff, with the right skills and experience to move the home forward. A 'dementia lead' position, for example, was soon to be recruited to and this role would support best practice in this particular area of care.

People lived in a clean environment as staff followed specific cleaning schedules. Measures were in place to reduce the risk of infection spreading. For example, staff wore protective aprons and gloves when attending to people's personal care or when handling food. Soiled laundry was segregated and managed separately from other laundry. Information had been shared with CQC that an outbreak of diarrhoea and vomiting, at the home, had not been correctly reported or managed. Public Health England had been informed of the outbreak and their advice had been followed by managers at the time.

There were arrangements in place to protect people from abuse and discrimination. The training record showed that most staff (three had not) had completed relevant training. Staff spoken with confirmed they had received this training. They knew what to observe for and how to report safeguarding concerns. Senior staff liaised with and appropriately shared information with other agencies and professionals in order to safeguard people. The provider's and the local authority's policies and procedures supported this approach.

Staff were aware of the provider's whistle blowing policy and procedures. They knew how to raise concerns about a colleague's practice or behaviour. One member of staff told us they had felt uncomfortable about another member of staff's approach towards a person. They told us they had been able to discuss their concern with a senior member of staff. The senior member of staff confirmed they had received the concern and told us how this would be addressed. This arrangement helped to protect people from poor practice, which may put them at harm.

People lived in a safe and well maintained environment. Arrangements were in place to ensure all equipment and main systems operated safely. This included for example, the water system, fire safety system, utilities and care equipment. We were provided with safety certificates and evidence of on-going monitoring and servicing which was carried out. The maintenance person kept concise and well maintained

records of the safety checks they carried out. Appropriate risk assessments and emergency contingency plans were in place.

Good

Is the service effective?

Our findings

The training and support which had been provided to staff had been reviewed by the deputy manager. They had found that not all staff had completed training, which the provider expected to be completed. This had been identified in the provider's last full audit of the home in late 2017. The staff training record showed where the gaps were and whether training had been booked already or was due for update. The deputy manager had taken a lead role in organising and booking all necessary training to address this. To support safe practice and improve staffs' skills and knowledge whilst staff waited for their training dates, the deputy manager had also held in-house training workshops. Staff told us they had found these useful. The deputy manager had also spent a lot of time working alongside staff, giving them guidance and support to further support best practice. The potential risks to people from staff not having fully completed all necessary training subjects had been reduced by this action. We observed staff to have varied levels of skill and confidence, but also observed people's needs being appropriately and effectively met.

Further workshops were planned, for example, on safeguarding and putting the Mental Capacity Act into practice. All new staff had completed the provider's induction training. This included basic health and safety training and an introduction to the provider's policies and procedures. Staff completed a probationary period during which their progress and suitability was reviewed. The provider's on-going "trust in conversations" scheme provided staff with opportunities to talk with managers about their training needs and future goals. One member of staff said, "There is support here when you need it which is lovely." Another member of staff told us they had felt, at times, as if they had been left to "get on with things", although, they also confirmed that the new managers had told them just to ask for advice and support when they needed it. Plans were in hand to provide staff who had taken on new roles and responsibilities with further professional development.

A pre-admission assessment was completed before people moved into the home. Information from this helped the registered manager decide if the home could meet a person's needs. At this point information was gathered from the person needing care (where possible), relatives and other health and social care professionals. There were also arrangements in place to assess the on-going needs of people who already lived in the home. This was to ensure received the correct level of care moving forward. The provider's policies and procedures met with the Equality Act 2010 and therefore people's diverse needs were accepted and met. Dependency assessments were completed and had been reviewed. We reviewed assessments for two people. These recorded a decline in their mental ability and therefore an increase in the level of support needed.

People were supported to make decisions about their care and treatment. Support required was provided in the least restrictive way. For example, where people required support to remain safe, technology was sometimes used. For example, sensor mats alerted staff to people's movement without the need for intrusive and constant monitoring by the staff. Beds which lowered almost to the floor were used instead of bed rails, which could be restrictive. Staffs' daily care records recorded how they promoted and supported independent decision making. For example, one person's daily care records clearly recorded the decisions they made on any given day and how staff aimed to provide support around these.

Where people lacked mental capacity to make independent decisions we checked to see if the principles of the Mental Capacity Act (MCA) 2005 were being followed. The 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. Where it had been suspected that people lacked the ability to make independent decisions, their mental capacity, in relation to the decision needing to be made, had been assessed. These assessments were recorded and for example, included the decision to live in a care home and decisions about their care and treatment. Any decisions made on behalf of a person were recorded. Records included who had been involved in the decision making and what the decision had been.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where required appropriate applications had been made by managers to deprive a person of their liberty. One person had authorised DoLs in place and there were no conditions attached to this.

People were supported to eat and drink and action taken to support people's nutritional wellbeing. People's weights were monitored as was their level of nutritional risk. People identified at high risk were included on the risk register and their progress discussed weekly, as well as with their GP. The chef had a good understanding of people's nutritional needs. Where people had lost weight their food was fortified so their food contained additional calories. This was achieved by adding extra butter, cream and powdered milk to the food. Two people preferred to walk and they rarely sat down so they required additional calories to prevent an unhealthy loss of weight. We observed staff following these people with drinks and snacks, making sure they had something to eat and drink as they walked. Where possible they encouraged them to rest and drink but without the intention of restricting their activity.

We observed people being given a choice at meal-time. People who lived with dementia were given extra support to do this. A visual prompt was given to some people by staff showing them plated meal options sitting side by side. One member of staff told us this approach had helped people's ability to make choices as well as reduce the amount of food wasted. Table menus, to help others remember what was being served on a particular day, were in the process of being produced. People who required support to eat their food were provided with this in a patient and kind way. The temperature of food was checked before it was served so as to reduce the risk of scalding. The dining area atmosphere was kept calm and quiet and staff moved around in an unhurried way. We also observed drinks being served in-between meals and choices being provided.

People told us they had access to their GP when needed. Arrangements were in place for a planned visit to the home, by a local GP, every other week. This provided some continuity in being able to review people's progress on an on-going basis with the same doctor. Other doctors visited when required. For non-emergencies outside of the local doctors' surgery hours, staff contacted the NHS 111 service. People accessed dental and optical services predominantly through the support of relatives, but support to access these services could be provided by the staff where needed. People's care records showed evidence of visits by various health care professionals. These included psychiatrists and community mental health practitioners as well as community nursing staff. We spoke with one member of the community nursing team who had visited to carry out health checks on some people. They said, "The staff are helpful and know the residents well." Care records showed that information and explanations about people's health had been shared with their relative/representative where this was appropriate to do so.

The home had been purpose built and guidance and advice had been sought during the design stage from Sterling University, on how best to support people who lived with dementia. The interior was specifically designed to make it easy to use and understand by those who lived with dementia. For example, one large building contained four smaller units called households. This promoted life in a more secure and smaller community, but there were spaces where people from all households could come together. For example, a central room on the ground-floor which could open up to the garden and which was partly designed as a coffee, come tea room.

People's living spaces connected to one corridor which flowed throughout the household. Each corridor had a destination point to avoid what could be perceived as a dead end. These all had a different theme to help people orientate themselves. They provided an area to sit and contained items, which could be carried away by a person without causing concern. Staff told us they simply returned these when people had finished with them. The communal rooms all flowed together but also provided areas where people could sit and be less stimulated. Small kitchen areas provided a domestic setting which was safe. For example, we observed one person wiping the kitchen tops down as they would have done in their own home, but items such as the cooker and hot water boiler had safety locks on them and could only be turned on with staff assistance.

The outside spaces had been used by people and were secure. These offered grassed areas with patios and decks, or large balconies for sitting on when on the second floor. The garden areas were to be developed more over time. Signage and colour was used to help people orientate themselves. For example, toilet signs were both pictorial as well as words. Additional adaptations had been made to support people's physical needs. For example, baths had hoists which lowered people into the water. Bedrooms had wide doorways which easily accommodated wheelchairs and care equipment.

The call bell system was silent, so when people pressed their call bell for help it came up on staffs' pagers. This prevented a noise being heard throughout the household which could potentially confuse and distress people.

Good

Is the service caring?

Our findings

We observed how staff interacted with people and how they managed situations which arose. We observed many acts of kindness and good practice. This told us staff understood the needs of people who lived with dementia and they wanted to improve their wellbeing. Three people in particular were prone to becoming agitated and distressed. The staff we spoke with showed an impressive understanding of each person's particular needs. They knew what could trigger an agitated or distressed response and had different strategies for helping each person to settle and feel secure. Staff referred to all the people they cared for in a fond and respectful way, however challenging some people's responses could be. People and relatives were full of praise for the staffs' professionalism as well as their kindness.

A personalised approach to care was promoted. Staff supported people to be as independent as possible but they also listened to them, about the times they wanted support. In some cases this approach had helped to build people's confidence, in other cases, with patience and understanding, meaningful relationships had developed. Staff had got to know people's families, their life histories and what really mattered to them in order to help achieve this. One person said, "They are very good about making sure I am comfortable and taking things at my pace. They never make me feel rushed and they always check that I'm happy before they do anything. I still feel awkward having to have help in the shower, but they do everything possible to put me at my ease. To tell the truth I actually enjoy the shower more than I used to because I'm not worried about slipping over."

One member of staff spoke with us about how they met the needs of one person. They spoke of being patient and of needing to understand how the person wanted things done. This member of staff said, "It about not taking your own agenda in with you. [Name] is exacting in how they want things done and that is okay." People confirmed staff involved them and those they wanted to be involved, in discussions about their care. Care records demonstrated that frequent conversations were also held with relatives (where appropriate) about their relative's care. These records also showed further discussions and explanations were given where these were needed.

People were shown respect and their dignity and privacy maintained. One person told us how staff helped them with their personal care and maintained their dignity during that time. They said, "The staff are quite discreet, they go out or turn their backs at just the right moment." A relative said, "Mum is a very shy and private person, so it has been hard for her to accept help with personal matters. I've seen for myself how respectfully 'the girls' treat her and their down-to-earth attitude definitely helps her feel less embarrassed."

A respectful and supportive staff culture was being promoted by the new managers. New staff told us they had an understanding of how change can be difficult. They told us they were keen to be as supportive as they could be towards their longer standing colleagues. The managers told us they wanted all staff, long standing and new to feel valued and to value each other's contribution. One member of staff, who had fairly recent experience of working in other care services, said, "It's really nice here and so friendly." They told us how staff had shown friendship towards them and supported them when they first started work.

Good

Is the service responsive?

Our findings

People's care was planned with them when they were able to be part of this process. Where they were not, an appropriate relative or representative was supported to be involved. We found people's choices and preferences had been considered when planning their care. One person's records contained entries of how the staff had tried to meet the person's particular preferences. On some occasions they had tried numerous times to accommodate these. People on one unit, were more able to tell us that they were consulted with and their views, preferences and choices were respected.

Care plans gave detail about people's health and care issues, their abilities and what support they needed. They gave staff guidance on how to support people's needs safely and in the way they preferred. Some care plans were particularly personalised and showed staff had taken time to get to know the person and talk with those who mattered to them. There was evidence of alterations to care plans when people's abilities and needs changed. For example, one person's care plan for personal care had been altered to record the person now needed support to clean their teeth. Care plans were reviewed monthly or before if needed. One person's mental wellbeing fluctuated significantly between good and poor. Reviews of the relevant written care plans reflected these changes and the altering care required. Good maintenance of these records meant staff had access to up to date guidance on a person's care and visiting professionals, had access to up to date information for their assessments.

People were supported to take part in activities which they enjoyed and which supported their social inclusion. Two members of staff were employed to help people with meaningful activities. We observed an activity attended by several people, which prompted much laughter, camaraderie and sharing of stories and memories. This activity was skilfully led and encouraged positive relationships between people. Everyone's contribution was valued and encouraged. This activity would not have been appropriate for some people, but we also observed a second activity which was. This activity was led by an external person who specialised in exercise for older people; two members of staff also supported people during this. They, for example, supported one person in a wheelchair by removing the footplates so they could carry out the exercises. This activity generated much laughter and one person said, "You can feel it doing you good."

The activity co-ordinators organised how they worked so that activities were provided during the early evening and part of the weekend, as well as during the week days. We observed a third activity where several people had gathered after the evening meal to have a glass of wine, chat, paint nails and "have a laugh" as one of them told us. Some people responded better to a one to one approach which the activity co-ordinators organised as well. We observed staff providing opportunities for people to have meaningful interactions with them or with others. Activities which allowed people to use retained skills also took place, such as baking. The friendship and meaningful interaction, provided by volunteers throughout the week, was a valuable addition to supporting people's quality of life.

Nobody living at the home had needed end of life (EoL) care since it had opened. However, there were staff who had experience in this area of care. EoL wishes and advanced decisions were explored with people and their relatives so staff were aware of these. Previously recorded EoL wishes [advanced decisions] were kept

in people's care files so staff were aware of these.

The provider had a complaints policy and procedures in place. Relatives said they now felt confident that they would be seen quickly and taken seriously if they had any concerns. The new managers were aware of some previous areas of dissatisfaction and complaint, which had not been resolved. The new managers had met with relatives and people to discuss their existing areas of complaint or dissatisfaction. Relatives told us communication was "very good - now". All relatives mentioned the 'open door' policy which was in place at The Lakes and said this worked well. A meeting between the new managers and a family, who had been previously dissatisfied with the services provided, had now resulted in positive feedback from them. The new managers were keen to learn from feedback received and to use this to drive improvements. There had been no new complaints since they had been in post.

Requires Improvement

Is the service well-led?

Our findings

A new and experienced home manager had been employed on 8 January 2018. They were in the process of applying to the Care Quality Commission to be the registered manager of the service. They were managing the home with the support of an experienced interim manager who had started work at the home on 27 December 2017. The interim manager had in-depth knowledge of the provider's policies, procedures and systems, which they were familiarising the new home manager with. Support was also being provided by an operations manager.

All managers were aware the home had lacked consistent management since it had opened in March 2017. They were fully aware of the challenges which had resulted from this and what improvements were needed to successfully move the home forward. They had completed extensive auditing and had talked with people, relatives and staff about this. Their initial task had been to ensure people were receiving safe care and support when they needed it. The decision to stop admissions for people with nursing needs was made by the provider to ensure this could be achieved. At the time of this inspection, the home was being well-led and improvements to the management of the home had resulted in safer care for people. These however, needed to be sustained in order for a rating of Good in 'is the service well-led?' to be awarded.

The first challenge had been to ensure the provider's safe ways of working were followed and to have the right staff employed, in the right positions, to do this. By the time of this inspection, the new managers had already placed staff, with the appropriate leadership skills and experience, in roles which would support this. One of these staff had been the new deputy manager, who brought with them experience in staff training and development. They had reviewed all staffs' training and support needs and had started to address these with good results. They worked alongside staff and provided them with the guidance and support they needed. One member of staff said, "Having a deputy manager in place and 'on the floor' and, who is very 'hands on' has made a great difference. We feel much more supported now."

Another key role, soon to be recruited to, was that of dementia lead. This role would provide support for staff in the area of dementia care. They're role was to ensure a dementia care pathway of care was followed so people received consistent and safe dementia care. A new management structure was being established, with staff who shared the new manager's visions and values for the home.

The new managers were involved in people's care and monitored the support being given to them. They were engaged in conversations with people's relatives about their relative's care. One relative said they were always now given an honest account of how their relative was doing and went on to say, "They [the staff] are always thinking creatively about how to promote [name's] wellbeing." Relationships with people and their relatives had clearly improved. The new home manager said, "It's all about good communication, keeping transparency and channels open." Another relative, said, they felt "very reassured and hopeful that the home would go from strength to strength under the new management team." A third relative said, "The new managers have changed things for the better and now the home is starting to be everything we hoped it would be when we chose it for [name]."

Managers had a good understanding of the culture in the home and had gone about improving this. They made themselves visible to people, relatives and staff and expected their senior staff to do the same. They were described as being approachable and helpful. One member of staff spoke about the support they had received from a team leader, whom they described as "really friendly and supportive." Another member of staff said, The managers are what they say they are." They told us the new home manager was often "out and about" [the home] and would help staff when they saw they needed help. They said, "I think it's the fact she has worked her way up so she knows what it's like to be a carer [care assistant]."

One member of staff said, "The changes are only going to help." When also talking about the approach of the new managers', another member of staff said, "It's better for staff but it's also much better for the residents. We feel empowered….and happy at work and of course that has an impact on the people who we look after. Yes, I'd say this is a nice place to work – now." One of the managers said, "There had been a need to change staffs' mind sets." They said, "We had to say, this is what we are going to do, but also explain why, so they [staff] had an understanding of why the changes were needed."

The provider's quality monitoring system and arrangements had been followed by the new managers. We saw audits completed in line with an annual program and, the provider had completed a full audit of the service in late 2017. This had identified areas for improvement. The new managers had considered these findings and the findings of their own audits to drive improvements. These had included the areas we had received concerns about and where previous ways of working had not allowed for best practice to be established. For example, the management of medicines, how risks to people's health were assessed and managed and improvements in staff knowledge and skills. We found this approach, along with specific plans of action had driven improvements across the home.

Managers had set actions with tight timescales in order to be able to methodically address areas of shortfall. They said, "We all agreed a plan and we knew who was looking at certain elements." This had resulted in improvements being made, for example, in medicine management, seen in the subsequent reduction of medicine errors, the improved identification, monitoring and management of people's risks and in staff support and recruitment. In-depth work had taken place and been carried out with integrity. There was a desire to make improvements, which could be maintained and sustained. However, time was needed before we could judge whether these systems had been effective in maintaining these improvements. For example, in the improvements in staff training and support, in medicine practice, the organisation of staffs' daily work and the benefits of further staff recruitment and retention.

The provider had arrangements in place to seek the views of people, their relatives and representatives. These included the use of satisfaction questionnaires which had not yet been used at The Lakes Care Centre. We reviewed feedback given by relatives on a website used for this purpose, which the provider also monitored. Positive feedback through this had been given between March and May 2017 but nothing since this. Managers explained they were completing a program of more personal care reviews with people and relatives. These reviews would involve asking people, and their relatives, about the care being delivered. Further appointments had already been organised for the coming month. The aim was to get a benchmark on where people felt their care and support was and to then make any necessary changes to this where needed. A similar review would then be held again in the future. The provider had also completed a staff survey in 2017 and feedback from this was due to be addressed by them.

The provider had in place arrangements which could provide staff with personal issues. They supported the services of a confidential staff support and counselling service. This organisation was separate from the provider and could be accessed by staff when they needed support. The provider also ran various initiatives and incentives, which recognised staff contribution and achievements.

Throughout the last year appropriate notifications had been made to the CQC of events which had occurred in the home. The provider had also notified us of the various changes in management. The new managers were fully aware of their responsibilities in maintaining communication with the CQC.

The new home manager had many ideas for new links to be made with the local community. They wanted to see the home taking part in more local activities and the community coming into the home and using it as a resource. In particular they wanted to set up a support group for relatives locally who look after people who live with dementia. They had already had discussions with some carers in the community who had looked for advice. Links were already established with a local church whose members came to the home and provided opportunities for worship and friendship. People had been supported to go out and enjoy the countryside around them as the home had shared access to transport with another of the provider's care homes.