Millennium Care UK Limited

Lakeside Nursing & Residential Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced inspection of Lakeside Nursing and Residential Home on 16 January 2015.

Lakeside is a care home that provides accommodation for up to 50 older people. At the time of our visit there were 45 people living at the home. It is located close to Worthington Lakes and Standish town centre, and is set in extensive grounds. The home has three floors and there is a passenger lift to all levels. The majority of rooms are for single use and some rooms have an ensuite toilet. There are two large lounges, a dining room and a conservatory on the ground floor.

At the time of our visit there was a registered manager who had been in post for approximately five months. A registered manager is a person who has registered with

Summary of findings

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 found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. There was one breach in relation to medication and one breach related to the assessment and monitoring of the quality of service provision. You can see what action we told the provider to take at the back of the full version of the report.

Medications were not always stored, recorded and administered safely and in accordance with the medication policy of the home. We also found one person was being administered drink thickener that had been prescribed for another person. The service had not properly assessed risks or recorded preferences related to self-medication. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider had failed to protect people from the risks associated with the unsafe use and management of medicines.

We saw that the service made frequent referrals to specialists when a health need was identified and we found evidence of effective nursing care having been delivered to people. However, we found one case where a referral had not been made to an eating and drinking specialist as would have been expected. We raised this with the nurse and a referral was made whilst we were still on site.

People living at Lakeside and their relatives spoke positively about the care and support they received. Staff and families both felt like they had developed good relationships with one another. People told us they felt their independence and privacy was respected and that they were confident that any concerns they might raise would be acted upon.

The manager had been at the service for around five months and was in the process of modernising systems and improving the quality assurance processes in the home. We found a nutritional risk assessment had been incorrectly calculated on several occasions and this had not been picked up before our visit. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider did not have effective systems in place to monitor the quality of service delivery.

Staff and families were positive about the leadership of the home and the changes being made.

We saw that meetings were held with residents, families and staff and we were told people were confident that any issues raised would be dealt with.

Staff had undertaken training essential to perform their role and additional specialist training had been carried out in order to provide effective support to people with specific needs. The service had also been responsive to people's changing health needs by carrying out assessment and purchasing required equipment such as profiling beds.

Some people living at Lakeside were found to show signs of having dementia. Improvements were required to make the environment more dementia friendly and support the independence of people who may have dementia living in the home. We have made a recommendation about 'dementia friendly' environments.

We saw a range of activities took place at Lakeside, including activities to involve people cared for in bed or with symptoms of dementia. People said they looked forward to the activities and staff had a positive attitude toward supporting people with activity and occupation. We saw that the home had undertaken a number of activities in support of charities and people told us they were proud of their achievements and contributions.

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?

Requires Improvement

Not all aspects of the service were safe.

One person was being given drink thickener not prescribed to them and they had not had their needs relating to eating and drinking properly assessed.

Cream medicines were not kept in locked storage and the service had not assessed risks or recorded preferences relating to self-medication.

Staff were able to describe signs of abuse and were aware of how to report any concerns. Information was displayed in the home to enable people living at Lakeside or their visitors to report concerns directly if needed.

People we spoke to told us they felt safe and we saw there were enough staff to meet people's needs.

There were plans and procedures in place to help ensure people were kept safe in the event of an emergency.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Lakeside is located in an older building and the environment was not dementia friendly.

We saw evidence of effective nursing care leading to positive outcomes for people.

The home was complying with the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff received essential training and other training to meet specific needs where required. People we spoke to felt the staff had the required skills to support them or their family member.

Staff received supervision that would ensure their support and development needs were met, however, not everyone was receiving supervision consistently as the manager was in the process of setting up new systems and procedures.

Is the service caring?

Good

The service was caring.

People living at Lakeside and their visitors told us staff were kind, caring, respected their privacy and supported their independence.

There was a consistent staff team and staff demonstrated they knew people very well.

Summary of findings

Staff and the manager felt they had developed good relationships with people's families, and the visitors we spoke to on the day were of the same opinion.

There were photos of people's named carers on their bedroom doors. This helped encourage open communication.

Is the service responsive?

Good

The service was responsive.

There were a range of activities on offer to people. These included activities people cared for in bed and people with additional impairments such as dementia could join in with. Staff had a positive attitude towards supporting people with activities and occupation.

The service had purchased specialist equipment and undertaken training in order to support people with changing health needs, or people identified as needing specialist support at time of referral.

People told us they knew how to make a complaint and would be confident in approaching staff or the manager to do so if needed.

People's care was reviewed on a monthly basis. Input from people living at Lakeside and their families was limited in formal reviews, however people did feel communication with staff was good and that any issues would be discussed as they arose.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

The registered manager had started work at the home around five months prior to the time of our visit. We saw they were still in the process of setting up systems to effectively monitor the quality and delivery of service.

There was a single monthly audit that was limited in depth. We found an error on a nutrition risk assessment that had not been picked up before our visit.

The manager told us it was important to act as a positive role model. We saw one way in which the manager did this was to provide direct support to people at meal-times.

Staff and visitors we spoke to felt the service was well led. They told us the manager was approachable and was making positive changes.

The manager and deputy spoke about how they worked well as a team as they had different sets of skills.

Care files were kept in an unlocked cabinet that could be accessed by people other than staff. There were usually staff in the same room to prevent this; however the manager said they would get a lock fitted.

Lakeside Nursing & Residential Home

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.

The inspection took place on 16 January 2015 and was unannounced. The inspection team consisted of one adult social care inspector, an adult social care inspection manager, a specialist advisor with expertise in nursing and dementia care, and an expert by experience. The expert by experience had personal experience of caring for an older adult using health and social care services.

We last inspected Lakeside Nursing and Residential Home on 7 January 2014, when we found the service to be meeting all standards inspected.

Before the inspection took place we reviewed information we held about the service. We reviewed the previous inspections, safeguarding records and notifications of accidents and other important events that the service is required to send us by law. We also contacted the safeguarding and quality assurance teams at Wigan Council who provided us with feedback.

On the day of the inspection we took a tour of the home and we viewed all areas including the lounges, dining room, people's bedrooms, the bathrooms, kitchen and laundry.

We spoke to nine people living at Lakeside and four relatives that were visiting the home during our inspection. As some people living at Lakeside were unable to tell us about their experiences living there, 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 talked to nine staff including the registered manager, the deputy manager, four care staff, one additional nurse, the chef and the activity co-ordinator. As we did not have opportunity to talk to everyone we wanted to on the day of the inspection, we spoke to the activity co-ordinator and one member of the care staff by telephone on 13 February 2015.

We reviewed five people's care files and used pathway tracking to ensure aspects of care were being received by the person using the service as was documented in their care plan. We reviewed paperwork including six medication administration records (MARs), three staff personnel files and other records related to the running of a care home. These included policies, accident reports and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

We found medication was not always administered safely and in line with the medication policy of the home. We found drink thickener prescribed for a person using the service was being used to thicken the drinks of another person living at Lakeside. This was contrary to National Institute for Health and Care Excellence (NICE) guidance and the home's medication policy that stated that medication must only be administered to the person to whom it is prescribed, and that medication must be disposed of safely following a person's death.

The nurse we spoke to told us this person had been given thickened drinks following a change in their health, and said they had responded well to changes made to their diet. We could see from reviews of the care plan that use of the thickener had started around four months earlier and the nurse confirmed this was the case. We asked the nurse to check if this person had their own prescription for thickener, and after checking with the pharmacist the nurse confirmed they did not.

The nurse also confirmed that a referral had not been made to an eating and drinking specialist such as a speech and language therapist (SALT) and that this person was eating a softened diet rather than pureed as detailed in their care plan. Whilst there was no evidence that there had been any harm to this person, there was a risk that they were not receiving the correct support to eat and drink safely as specialist advice had not been sought.

Information such as how thick to make drinks and details of this person's current diet were not accurately reflected in the care plan. The nurse said staff were aware of this person's care needs as any changes were communicated in handovers. However, there would be a risk if there was a change in staffing, that new or temporary staff would not know how to support this person correctly with eating and drinking.

During the inspection we were informed that arrangements had been made to obtain a prescription for the thickener and that a referral had been made to a Speech and Language Therapy (SALT).

The thickener and other cream and liquid medications were not kept safely. We saw creams had been left on people's bedside tables rather than being in locked storage. There was no evidence in care files of risk assessment or assessment of capacity relating to these medications being stored separately from other medications kept securely in locked storage. As these medications were accessible to people living at Lakeside and others visiting the home there was a risk that they could be used in a way that was not safe or could go missing.

We found administration of medication was not always accurately recorded. One medication administration record (MAR) chart we looked at indicated that the gap between doses of paracetamol was three and a half hours rather than the required safe gap of four hours. We queried this with the nurse on duty who told us that the individual was given the medication at the time indicated on the MAR, but did not take it until half an hour later, and was observed taking the medication at this time.

We were told that was how that individual wanted to receive their medication. This showed that care was being delivered in a person centred way, however, there was no recorded process or risk assessment in place to ensure any associated risks had been appropriately managed. There was also a risk that if staff who were not familiar with that person's care were required to administer the medication, that it may not be given at the correct time.

We were told another individual self-administered an inhaler. However, we saw that staff had signed the MAR chart to show they had taken responsibility for administering this medication. The nurse said staff would have been asking that person if they had taken their inhaler. There was no assessment or documented process that recorded people's preferences or competence around self-medication in this or any of the care records we viewed that would ensure self-administration was carried out safely.

We asked two members of staff about the procedure they would follow if they noticed there had been a medication error. Both staff were able to tell us how they would report and follow-up concerns but were not aware of the procedure detailed in the medication policy that required an incident report to be completed. This meant there was a risk that medication errors would not be recorded and followed-up appropriately.

Requires Improvement

Is the service safe?

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the provider had failed to protect people from the risks associated with the unsafe use and management of medicines.

All of the people we spoke to told us they felt safe, and all but one person thought there were enough staff. This person told us they sometimes had to wait for staff to assist them. One person said "I feel like there are enough staff and I feel like they are always here, definitely always nipping in to see me. I feel safe, always". This person had limited mobility and we saw that staff ensured they were comfortable and could access the call bell should they need it. All the relatives we spoke to told us they thought there were enough staff and that the service was safe. One visitor said "I visit every day, they all work very hard. They have a system and if you ask anything they do their best to help out". During the inspection we saw there were sufficient numbers of staff to meet people's needs. We confirmed staffing levels by looking at staff rotas and speaking to staff.

We noted there had not been any safeguarding alerts raised by the home in the past 12 months. The registered manager told us she was confident that all staff would be able to recognise signs of abuse and would report any concerns. Staff were able to tell us how to recognise signs of potential abuse or neglect and were aware of how to report concerns within the home. Two members of staff we spoke to were not sure who the other agencies were that they could report safeguarding concerns to outside the organisation if needed. However, they were aware there was a safeguarding policy and that they could find the details there.

Staff told us they had received safeguarding training and we saw training certificates that confirmed this in the staff files we reviewed. A safeguarding board had recently been placed at the entrance to the home that displayed the safeguarding policy, details of training and a contact number for the local authority safeguarding team. This would help ensure staff, people living at Lakeside and any visitors would be able to report concerns if needed.

We asked staff how they would report any accidents that occurred and were told they would be recorded in an accident book and emergency services called if needed. One member of staff told us they had completed an accident form the previous day and that the manager would review it. We confirmed this by speaking to the manager who said they monitored accidents for any trends such as the times and locations of falls and would take the required actions including making referrals to specialists if needed. We saw the accident form that had been completed the previous day, and this had been completed with sufficient detail to allow the manager to do this.

The manager discussed the action plan in place for any emergency events that could prevent care being carried out. We looked at a written copy of the plan and saw that it had been reviewed within the last six months. The manager also told us how they had introduced a simple system of colour coding files to indicate quickly what support an individual required in case an evacuation was required. We also saw that risk assessments had been completed for the environment and individuals in their care plans. This told us plans and procedures were in place to keep people safe in the event of an emergency, and that risks to people had been considered and controlled where possible.

Recruitment procedures were in place to ensure only staff suitable to work with vulnerable adults in care and with appropriate qualifications had been recruited. We saw staff had been interviewed, references had been obtained and a Disclosure and Barring Service (DBS) check carried out. We also saw a file that confirmed nurses' PIN numbers had been checked, to ensure they were qualified and not barred from practice.

The environment at Lakeside was visibly clean. However, we found areas including corridors and stairwells were being used to store equipment such as hoists and other items that were due for removal such as old furniture and wheelchairs. This presented a potential hazard to people with impaired mobility and or vision. The manager told us a skip had already been booked and the items to be discarded would be removed the following week.

We spoke to one member of staff about their responsibilities relating to infection control and they were able to explain the home's policy including use of personal protective equipment (PPE). We observed there was guidance in the staff toilet on hand washing. We looked at a cleaning schedule on the back of the door that had been fully completed. This demonstrated that the service maintained a clean environment, which would help prevent spread of infection.

Requires Improvement

Is the service effective?

Our findings

All of the people we spoke to commented positively about the care they received and felt the staff were skilled. One person told us; "They just get involved. Very good staff, they all seem to know what they're doing, I know them all". Relatives of people we spoke to also told us they felt the staff had the required skills to care for their family member. They said they were kept informed of any changes to the health of their family member.

Much of Lakeside Nursing and Residential Home was located in an old building and we found that the design of the building could sometimes affect the care people received. One person told us they sometimes had to wait a long time for staff to assist them to the toilet. We spoke to a member of staff who said that people were supported to the toilet regularly and as required. However, due to their being a limited number of toilets that were accessible to wheelchair users, this could sometimes mean people had to wait for a suitable toilet to become available. They also told us that as there was only one shower on the first floor this meant some people had to be taken downstairs to receive a shower.

Lakeside was not run as a home specifically intended to support people with dementia. However, we found that some people living at Lakeside did have symptoms or a diagnosis of dementia. There were no adaptations such as different coloured doors, memory boxes, or accessible signage that would enable people with dementia to retain independence in their home. Some areas of the home were not dementia friendly such as heavily patterned wall-paper and carpets, which could be confusing for some people with dementia. We spoke with the manager and the provider about this who told us they had worked with specialists in dementia care to adapt environments at other locations. They said they had not previously considered doing this at Lakeside as it was not a specialist dementia service. .

We recommend that the service explores relevant guidance on how to make environments used by people more 'dementia friendly'.

We reviewed people's care files and saw that people's health was well monitored, for example through nutritional assessments and recording people's weights. Other than in the one case discussed in the safe section of this report where a referral to an eating and drinking specialist had not been made, documentation showed that referrals to specialists including GPs were made if there were any concerns or changes to an individual's health. We saw records and discussed two cases with the nurse that demonstrated how good nursing care in relation to wound care and pain management had led to positive health outcomes for those people.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We found the service was complying with the legal requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The manager was aware of recent developments in practice and was submitting DoLS applications to the Local Authority to an agreed schedule. One person had an authorised DoLS in place and we saw evidence that a best interest process involving family had been followed. The application had been renewed in advance of its expiry. The manager was also aware of the need to involve an Independent Mental Capacity Advocate (IMCA) where an application was being made for someone who did not have family involved in their care.

Staff told us they had received training in the MCA and DoLS, which we confirmed by looking at the training matrix and staff training certificates. They were able to explain how they supported people effectively who may not have the capacity to make decisions for themselves. This included presenting simple choices, reading care plans and acting in someone's best interests. Staff were also aware of the person they supported who had a DoLS authorisation granted and what this meant in respect of their care and support. We saw that mental capacity assessments had not always been completed on admission. However, the manager showed us new paperwork that included an assessment that was now being used for each new admission. We saw an example of where this paperwork had been completed for someone moving into Lakeside. It was noted that the role of family members in a person's

Requires Improvement

Is the service effective?

care, for example if the person wanted them to be involved in reviews of care, was not always clearly recorded. We found however that staff were aware of people's wishes relating to family involvement.

During our inspection we checked to see how people's nutritional needs were met. Most people told us they enjoyed the food on offer and that they could choose where they ate. People were also able to request food outside meal times. One person said "If I'm hungry they will sort out a sandwich in my room". When asked about the food, one person said "Brilliant" and another said "Yes food's good". Other people were less positive, one person said "Food is adequate, meat and two veg, always more if you want it" and another person said they would like more choice and said "it's traditional, a bit bland at times…". The chef was aware of people's dietary requirements including any special diets such as for people with diabetes. The chef demonstrated a good knowledge of people's food preferences, although this was not formally recorded. We observed the mid-day meal and members of the inspection team described the environment as very relaxed and pleasant.

Staff told us they received supervision and that it was a useful tool to support them in their roles. Supervisions and appraisals enabled managers to assess the development needs of their staff and to address training and personal needs in a timely manner. However, one staff member commented that it could be "a bit random" when they received supervision. Seven of the 37 staff on the supervision tracker that had not received supervision since the tracker was started around four months previously. The manager discussed how since starting in post they had been conducting initial supervisions and would soon have the assistance of the other senior staff to ensure these were completed on an on going regular basis.

Staff received essential training at induction including safeguarding, fire safety, moving and handling and infection control. We also saw that additional training had been undertaken to enable effective care to be provided to people with specific needs such as diabetes and end of life care. The training matrix showed that twelve staff had undertaken training in dementia, and two of the staff we spoke to said they had not received training in dementia but had knowledge of how to support people with dementia from previous experience. One of the staff we spoke to said they thought dementia training would be useful for any newer staff at Lakeside.

The manager showed us a skills matrix that they used in order to plan shift cover, which ensured staff with the required mix of skills to support everyone at Lakeside were on hand for each shift.

Good

Is the service caring?

Our findings

People living at Lakeside told us they felt that staff were caring and respected their choices and privacy. Some of the comments we received were "Staff know what I want, listen for example. I'm independent and staff respect that"; "Staff listen and act on what I say" and "Everyone is nice, kind and friendly… I'd recommend it to anyone".

We saw visitors coming into Lakeside throughout the day and residents and visitors told us there were no restrictions on when they could visit. The manager and staff members told us they felt they had very good relationships with relatives. The visitors we spoke to confirmed this. For example, one visitor said "Whatever I say, they listen, react and take on board. They are approachable". Another visitor told us staff were always very caring and welcoming. They said staff had been very supportive when their relative had moved into the home.

There were four recorded compliments in the compliments file and two recent cards received from relatives that were very complimentary about the home and the care their relative had received. The manager told us agency staff were not used, and all shifts were covered within the staff team. This helped ensure consistency of support and facilitated the development of positive relationships between staff, people living at lakeside and their relatives.

The staff we spoke with all demonstrated they knew people living at Lakeside very well and had a good awareness of their support needs, likes and dislikes. We asked staff how they ensured the support they gave to people was person centred. Staff spoke about the importance of talking to people, giving people choices and getting to know them, as well as speaking to others involved in their care such as friends, relatives and professionals. Staff also told us it was important to know about people's histories and what they used to do. One member of staff gave us an example of how they adapted their approach with different people based on knowledge of how that individual liked to be supported. This staff member also told us calling people by a preferred name was important in providing person centred care, and from our observations and discussions with staff it was apparent they did this.

We observed staff were respectful in their interactions with people and staff spoke warmly to us about the people they supported. Throughout the day we saw people were confident in requesting assistance which was given promptly. Our observations of the mid-day meal were that care was carried out in a relaxed manner and people were supported at their own pace.

We asked one staff member how they were able to communicate effectively with an individual that had limited verbal communication. They explained in detail how they could understand this person's needs through observing their behaviours and understanding of different gestures they made. They also told us that this individual had a good understanding of what was said to them. This showed that staff were able to communicate effectively with people at Lakeside.

We saw people had a photo of a named carer on their bedroom door with the carer's name underneath. Two of the people we spoke to talked about their main carer and one pointed to the photo and told us that was their carer. This showed that effective ways to encourage communication and develop relationships had been considered. There was information available about independent mental capacity advocacy (IMCA) services on a noticeboard in the dining room, and the service user handbook contained information about general advocacy services. This meant people at Lakeside and any visitors had details about services they could contact if they felt they or their relative needed someone to advocate on their behalf. However, we noticed that the handbook hadn't been updated for some time and some of the details such as the current manager's name were not up to date.

When we asked about training, two of the staff we spoke to told us about end of life care training they had attended. These staff and another member of staff all spoke enthusiastically about offering good, person centred end of life care to people. The staff that spoke about the training told us it had provided them with confidence and were able to tell us how it had a positive effect on the support they provided to people approaching the end of their life.

Good

Is the service responsive?

Our findings

Lakeside had an activity co-ordinator who worked four mornings per week. They told us they worked flexible hours/days in order to arrange and support a range of activities in the home. On the day of our inspection we saw a seated exercise group taking place. People we spoke to on our arrival were aware that this regular session was due to take place and told us they were looking forward to it. We asked people what other activities took place and they told us there were activities such as quizzes, art sessions, knitting, concerts and trips out. One person we spoke to told us they looked forward to the arranged activities, concerts and art sessions and said "I'm doing things now that I never thought I'd be able to do".

There was a positive approach to engaging people in activities that met their personal interests. Staff spoke about reviewing people's personal histories and said it was important to understand what people used to do as well as what they wanted to do now. One staff member told us activities were continuous and not just something that should wait until the activity co-ordinator was in. We asked the activities co-ordinator and staff how they were able to involve people in activities who had limited verbal communication, more advanced dementia or those who were cared for in bed. Staff told us the activity co-ordinator involved people cared for in bed in the quizzes and activities such as beauty and nail sessions as they wished. The activity co-ordinator also told us they would adapt the activities such as the quiz by providing more simple choices and using non-verbal communication to help those with limited communication or cognitive impairment to take part in activities. They also told us there was a library service and that people could borrow accessible materials such as audio books if wanted. There were also reminiscence sessions that were accessible to people with dementia.

People had their spiritual needs met through activities such as visiting church services. One person told us "They take the trouble to take X to an indoor religious service on site every couple of weeks or so and give X a blessing. They used to go to church". People at Lakeside had been involved in a number of charity events including making knitted poppies for remembrance day and making blankets that were sent to a charity working in Africa. One member of staff told us how everyone at Lakeside involved in this charity work felt a great deal of pride and a sense of achievement at what they had done for the charities, particularly when they received acknowledgement of their contribution from the charities they donated to.

The registered manager told us they would only accept referrals if they had the skills and ability to meet the person's needs. The deputy manager highlighted that they were willing to learn new skills in order to meet people's needs and gave us an example of where they had undertaken specialist training in order to be able to support a person to move to Lakeside and be cared for effectively. The registered manager told us they had purchased specialist equipment such as profiling beds in response to people's changing health needs.

The home's complaints policy was displayed on the wall. This would help people living at Lakeside and any visitors raise a complaint should they need to. We asked three people living at Lakeside, and two visitors if they knew how to make a complaint and would they be confident in doing so. All told us they would be confident in approaching staff or the manager to raise a complaint should they need to. The manager told us there were no current complaints, and there were no complaints evident in the complaints file.

We saw care plans regularly reviewed and were detailed. Life histories were included in people's care plans. However, some were completed in more detail than others. When discussing how to effectively communicate with an individual with limited verbal communication we found the staff member was able to explain their support needs in detail, however they told us this information would not be recorded in that person's care file. Whilst there was a stable staff team at Lakeside at the time we visited, should this change in the future there would be a risk that this information would be lost.

Staff told us they had time to read people's care plans and that this helped them to provide care and support that was specific to that person's needs. Our observations confirmed this as we saw examples of staff supporting people in line with the approaches detailed in the care plans we had looked at.

The manager told us people received formal reviews on a monthly basis and we saw evidence of these having taken place in the care files we looked at. Whilst some of the people we spoke to were aware they had a care plan, the majority of the people we spoke to living at Lakeside and

Good

Is the service responsive?

their visitors said they were not involved in reviews of care. However, the same people were happy with the care they or their relative received and felt any issues would be discussed as they arose. It was also evident from discussion with visitors and staff that family were involved in care planning on an informal basis.

The manager told us resident surveys were sent out on a quarterly basis, and resident and relatives' meetings were held every other month. We saw minutes of these meetings and they appeared to be a useful forum for people. One person said "They have carers' meetings and always put it on a notice board to notify everybody and anybody can join it", and another person said "At community meetings things get resolved".

The manager told us they had been visited by a fire safety officer and as a result of this had upgraded the alarm system to one with magnetic fire door releases. They also said they had painted white lines on the step edges to make them more visible as the result of feedback from relatives. This showed the manager listened to advice and suggestions in order to ensure the environment was a safe for people living at Lakeside.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place. 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 registered manager had been in post for five months at the time of our visit. It was apparent from discussions with the manager and from reviewing records that the manager was in the process of modernising systems and procedures. The manager told us this was one of their biggest challenges and that when they had started there was no computer in the office. We saw the manager had set up electronic records to monitor supervisions and training since they had started.

We discussed how the change in management had been received in the home. The registered manager said they felt it had gone well and told us they had received positive feedback from relatives who said the home now had a more relaxed atmosphere. All the staff we spoke to felt the home was well led. One member of staff told us they felt the home was well led and was now "more relaxed" and "a happier place". The registered manager and deputy manager discussed how they felt their skills complemented each other well and they enjoyed working together.

We saw and the registered manager acknowledged that they were still in the process of developing systems to adequately monitor the quality and safety of the service delivered. The registered manager said they completed a daily walk round, though this was not documented. We saw records of a single monthly audit undertaken by the registered manager. This covered areas including spot checks on staff provision of care and support, care plans, medication, accidents and health and safety. The audit was limited in depth and detail and it was not always clear whether identified actions had been completed. For example, we saw the part of the audit relating to medication consisted of a small box. The registered manager had sampled five MAR charts and found one missing signature with an action to check with the member of staff, though it was not clear what the outcome of this had been. We saw that the medication policy included a template for a full audit of medication. The registered manager told us they were planning on implementing this.

We also found that the score on one of the nutritional assessments we reviewed had been miscalculated on several occasions and incorrectly indicated the individual was at high risk. From discussions it was clear that the staff were aware of this individual's health needs and there had been no detrimental effect to this individual. This issue had not been picked up prior to our visit however and highlights the need for a more robust quality assurance and audit process. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as the service provider did not have effective systems in place to monitor the quality of service delivery.

The registered manager was aware of their responsibilities relating to submitting notifications to CQC as is a legal requirement of their registration. We saw the registered manager kept a record of all notifications sent to us. We asked the registered manager how they encouraged good practice within the home and they told us they thought it was important to act as a positive role model. The registered manager said one way in which they did this was to support people over mealtimes. We saw this happen on the day of the inspection and a member of care staff we spoke to also confirmed that the registered manager provided support at meal times and when extra assistance was needed.

The registered manager told us team meetings were held every other month. We saw from minutes of the meetings that these covered mainly operational aspects such as infection control procedure and hand washing. The staff told us they however that they would feel confident in raising any concerns or issues they may have, and felt that the manager was approachable. Every month staff were asked to review a 'policy of the month'. In recent months, policies shared had included whistleblowing, equality and diversity, and DoLS. This meant staff got the opportunity to routinely update their knowledge about the manager's expectations in key areas.

We saw that a number of files were kept in view of people eating at tables in the dining room including care files and files with templates of forms labelled "notification of death" and "resuscitation status". The care files were in a

Requires Improvement

Is the service well-led?

cabinet with glass doors, which was not lockable. It appeared that there were usually staff present in the dining room; however, there was a risk that people's personal information in care files could be accessed by people other than staff. We mentioned this to the manager who said they would get a lock fitted that could be used when the area was not staffed.

The staff we spoke to during the inspection were positive about the home. One member of staff commented "it's the best home I've ever worked in". We asked three staff, including the manager, what they thought the best things about Lakeside were. All three spoke about having good relationships with the families of people living at Lakeside as well as enjoying a positive reputation within the local community.

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 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 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People using the service were not protected from risks associated with the unsafe recording, administration, storage and disposal of medication.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **People using the service were not protected from the risk of inappropriate or unsafe care and treatment as there were not effective systems in place to enable the registered person to assess and monitor the quality of the services provided.**