Millennium Care (U.K.) Limited

Lakeside Nursing & Residential Home

Inspection report

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Date of inspection visit:
17 January 2017
18 January 2017

Date of publication:
17 February 2017

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?	Good

Summary of findings

Overall summary

This comprehensive inspection took place on 17 and 18 January 2017 and was unannounced. The inspection team consisted of one adult social care inspector. At the time of the inspection, there were 46 people living at the home. Lakeside Nursing and Residential Home is registered to provide personal care and support for up to 50 people. It is situated close to Worthington Lakes and Standish town centre.

There was a registered manager in post. 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.

People we spoke with who lived at Lakeside Nursing and Residential Home told us they felt safe.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service.

We looked at five staff personnel files and there was evidence of robust recruitment procedures in place.

There was an up to date safeguarding policy in place, which referenced legislation and local protocols. Staff told us they had received safeguarding training and we saw training certificates that confirmed this. The home also had a whistleblowing policy in place.

We looked at how the service managed the administration of medicines. At the last inspection on 25 August 2015 there were no 'when required' (PRN) protocols in place and no information on medicines recorded in people's care plans. At this inspection we found that the registered manager had introduced 'when required' protocols and detailed information on medicines was now in people's care plans. We observed staff administering medicines and saw that people were given their medicines as required. Records of medicines administration had been completed consistently and accurately. We saw requirements relating to controlled drugs were being met. We saw medicines were stored safely in a locked medicines trolley in the treatment room which was very clean.

The home was adequately maintained and we saw evidence recorded for the servicing and maintenance of equipment used within the home to ensure it was safe to use. We saw that monthly infection control audits were in place and included areas such as beds and mattresses, furniture, bedrooms and the general environment and equipment. There was an up to date a fire policy and procedure. Fire safety and fire risk assessments were in place.

We saw people had risk assessments in their care plans in relation to areas including falls, pressure sores, and malnutrition. Accidents and incidents were recorded correctly and included a record of the accident or incident, a summary chart and action plan.

There was a staff supervision schedule in place, which identified meetings during the year and staff were subject to a formal induction process and probationary period. Comprehensive staff training records were in place and staff had completed training in a variety of other areas relative to their job role.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the service was complying with the conditions applied to the authorisations. Staff had received training in the MCA and DoLS and most were able to explain the principles of this legislation to us. Staff were aware of how to seek consent from people before providing care or support.

Special diets were catered for, food allergies were recorded and people had nutrition and hydration care plans in place. People who used the service also commented positively about the food.

We saw staff showed patience and encouragement when supporting people.

People's relatives told us they felt staff were caring when assisting their relative. Staff spoken to had a good understanding of how to ensure dignity and respect when providing care and support and people we spoke with confirmed that they felt staff respected their privacy and dignity and promoted their independence.

Staff interacted with people throughout the day and it was clear that they had a good understanding of the individual people who used the service.

Peoples' spiritual needs were accommodated through the regular attendance at the home of different faith groups.

People's care files contained end of life care plans, which documented people's wishes at this stage of life where they had been open to discussing this.

We observed staff were patient, respectful and friendly towards the people who lived in the home.

Care files were well organised and contained care plans that covered a range of health and social care support needs. People's needs for support were carefully described on their care plans so care staff knew exactly what tasks to undertake.

We saw people had a choice of activities to stimulate them and activities previously undertaken were recorded in people's care files.

Residents and relatives meetings were held regularly. People's care files identified that individuals and their relatives were involved in the planning of their care, and personal preferences were discussed.

There was a complaints policy and procedure in use and this was up to date.

People who used the service and their relatives spoke positively about the management team. Staff said they liked working at the home.

Staff supervisions were undertaken regularly and we saw that these were used to discuss issues on a one to one basis.

There was a business continuity management plan in place that identified actions to be taken in the event

of an unforeseen event.

The service worked in partnership with a wide variety of organisations and professionals. There was a full range of policies and procedures in place which were available in paper copy format and electronically.

People's care records were kept securely and confidentially, and in accordance with legislative requirements.

There was a service user guide and statement of purpose in place.

There was an up to date certificate of registration with CQC and insurance certificates on display as required.

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.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service and there was evidence of robust recruitment procedures.

People we spoke with who lived at Lakeside told us they felt safe.

Records of medicines administration had been completed consistently and accurately.

Is the service effective?

Good

The service was effective.

Staff were subject to a formal induction process and probationary period and there was a staff supervision schedule in place.

Staff were aware of how to seek consent from people before providing care or support. People's care plans contained records of visits by other health professionals.

There were some adaptions to the environment to assist people living with a dementia.

Is the service caring?

Good

The service was caring.

Staff spoken to had a good understanding of how to ensure dignity and respect and staff showed patience and encouragement when supporting people.

We heard lots of chatter between staff and people and there was a positive atmosphere within the home.

Relatives spoken to said staff were kind and caring.

Is the service responsive?

Good

The service was responsive.

Care files contained care plans that covered a range of health and social care support needs.

People's care files identified that individuals and their relatives were involved in the planning of their care.

Each person had an assessment of possible risks and a description of the person's needs for support and treatment.

The home had procedures in place to receive and respond to complaints.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post.

There were a variety of systems in place which helped the service to monitor the quality of care provided and the service undertook a range of audits.

Staff received supervision in accordance with the frequency identified in the supervision policy.

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.

This inspection took place on 17 and 18 January 2017 and was unannounced. The inspection team consisted of one adult social care inspector. At the time of the inspection, 46 people were living at Lakeside Nursing and Residential Home.

Prior to the inspection we reviewed information we held about the home in the form of notifications received from the service such as accidents and incidents. Before our inspection we contacted Wigan local authority commissioning team to find out their experience of the service.

We spoke with five people who used the service, five relatives, four members of care staff, kitchen and domestic staff, two nurses and the registered manager who was also a nurse. We also looked at records held by the service, including five care files and five staff personnel files.

As part of this inspection we 'case tracked' the records of two people who were using the service. This is a method we use to establish if people are receiving the care and support they need and that risks to people's health and well-being were being appropriately managed by the service.

We looked around the premises and observed the delivery of care throughout the day. This also included a medicines round and lunchtime meal.

Good

Is the service safe?

Our findings

People we spoke with who lived at Lakeside Nursing and Residential Home told us they felt safe. One person said, "It's brilliant here, the staff do everything for you and I feel very safe living here. My family set up my room before I came in and it felt great." A second person told us, "As for my day to day care, it's second to none." A visiting relative commented, "When [my relative] came in to the home she was at the end of life and the doctor warned us of this; but she's still here and it's all down to the staff group, they're lovely."

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service. We looked at the staff rotas for January 2017 and these consistently demonstrated that there were sufficient care staff on duty to meet the needs of people using the service. There were eight care staff and three nurses during the day and one nurse and four care staff during the night. The registered manager told us that staff turnover was very low and this ensured consistency of support and familiarity with people who used the service.

The service used a formal dependency tool based on people's priorities for care and changing needs, when determining staffing levels. From this an upper and lower staffing level average was calculated identifying how many staffing hours were required to safely meet people's needs. We looked at historic information regarding staffing levels and checked staff rotas which identified the service consistently operated with staffing levels above the average required level identified in the dependency tool.

The service used the NHS Safety Thermometer which provided a quick and simple method for surveying harm to people in a variety of areas such as falls, pressure ulcers and infections. Results were analysed, which could be measured and used to monitor local improvement and harm free care.

We looked at five staff personnel files and there was evidence of robust recruitment procedures in place. The files included application forms, proof of identity and references. Disclosure and Barring Service (DBS) checks were completed for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people. Staff we spoke with confirmed they had been subject to this recruitment process.

There was an up to date safeguarding policy in place, which referenced legislation and local protocols. Staff we spoke with demonstrated an awareness of safeguarding and were able to describe how they would make a safeguarding referral. Staff were aware of potential signs of abuse or neglect and of how to report any safeguarding concerns appropriately. Staff told us they had contact numbers for the local authority safeguarding team should they need it.

Staff told us they had received safeguarding training and we saw training certificates that confirmed this. A safeguarding board was 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.

The home had a whistleblowing policy in place. We looked at the whistleblowing policy and this told staff what action to take if they had any concerns and this included contact details for the local authority and the Care Quality Commission. Staff we spoke with had a good understanding of the actions to take if they had any concerns.

We looked at how the service managed the administration of medicines. We also looked at medication administration records (MARs) of five people. At the last inspection on 25 August 2015 there were no 'when required' (PRN) protocols in place and no information on medicines recorded in people's care plans. 'When required' protocols provide information on when 'when required' medicines should be administered. At this inspection we found that the registered manager had introduced 'when required' protocols and detailed information on medicines was now in people's care plans. PRN medicines were now were recorded on peoples' MAR charts and there was a separate topical creams chart which identified specific areas for application for staff to follow.

We observed staff administering medicines and saw that people were given their medicines as required. When supporting people to take their medicines we observed staff to be patient and encouraging, ensuring people had a drink to assist with easy of swallowing tablets where necessary. Staff who administered medicines had all completed appropriate training in the safe handling of medicines, and observations of practice had been carried out to ensure the staff member could administer medicines safely.

Records of medicines administration had been completed consistently and accurately. One person told us, "I always get my medicines on time and have never missed any and if there is anything the matter with me they get onto it straight away."

We saw requirements relating to controlled drugs were being met. For example, we saw there were two signatures when controlled drugs were administered, which were stored in a separate, locked controlled drugs cabinet. Controlled drugs are certain medicines that are subject to additional legal controls in relation to their storage, administration and disposal. We carried out a stock check of controlled drugs and found that this was correct.

Any overstock of medicines was clearly identified with the persons' name and stored separately in preparation for collection by the supporting pharmacy. Disposal records were completed appropriately.

We asked a nurse about the procedure they would follow if they noticed there had been a medication error. They were able to tell us how they would report and follow-up concerns including the need to complete an incident report.

We saw medicines were stored safely in a locked medicines trolley in the treatment room which was very clean. Fridge temperatures were checked daily and a new fridge had been purchased that allowed the checking of temperatures without the need to open the fridge door, which assisted with the safe storage of these medicines.

During the inspection we looked around the premises. The home was adequately maintained and we saw evidence recorded for the servicing and maintenance of equipment used within the home to ensure it was safe to use. The premises were clean throughout and free from any malodours. We saw that bathrooms and toilets had been fitted with aids and adaptations to assist people with limited mobility. We saw that liquid soap and paper towels were available in all bathrooms and toilets. The bathrooms were well kept and surfaces were clean and clutter free and the home was clean throughout. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all the cleaning

products in use.

We looked at how the service managed the control of infectious diseases. We saw that monthly infection control audits were in place and included areas such as beds and mattresses, furniture, bedrooms and the general environment and equipment. Personal protective equipment (such as gloves and aprons) were available throughout the home. Weekly and daily cleaning schedules were in place and up to date.

Staff were aware of precautions to take to help prevent the spread of infection. For example, staff said they would wash their hands regularly and use different coloured cleaning cloths for different areas of the home. There was an infection control policy and procedure in place that identified to
staff what actions to take to minimise the potential for an infectious outbreak and the action to be taken in the event of an outbreak.

We saw people's care plans contained relevant information relating to areas such as falls, pressure sores, and malnutrition. Accidents and incidents were recorded correctly and included a record of the accident or incident, a summary chart and action plan. We checked historical accident records and found that they had been appropriately completed and included a body map identifying the area of injury (where applicable) and the action to be taken to reduce the potential for further injury in the future.

There was an up to date a fire policy and procedure. Fire safety and fire risk assessments were in place. People had an individual risk assessment regarding their mobility support needs in the event of the need to evacuate the building and there was a business continuity plan in place which identified what actions to take in the event of the need to evacuate the building or as a result of the loss of essential service such as the utilities supply. Tests of the fire system were made regularly and the servicing of related equipment, such as fire extinguishers was up to date.

Good

Is the service effective?

Our findings

The people we spoke with and their relatives spoke highly about the care they received. A person who used the service told us, "If you need to loo, staff are there straight away; having an en-suite bathroom in my room is wonderful. I can't speak highly enough of all the staff." A second person said, "I think they're all good and competent and the manager comes in and talks to me regularly." A third person told us, "I was poorly when I came in and what they have done for me has been wonderful. It's like a family here and it's nice to be among good people." A visiting relative commented, "There seems to be enough staff around and there's a good mix of ages as well which I think helps; staff are really friendly and go above and beyond I think. When I asked about funding from the hospice, the staff found out about this straight away and I was impressed with this. Communication is excellent."

We found that some people living at the home had a diagnosis of dementia. We saw that some rooms such as bathrooms, toilets, dining area, the lounge and hairdressing room had been fitted with pictorial signs that would assist people to orientate around the building. At the time of the inspection we saw that several areas of the building were being redecorated and one bedroom was being fully refurbished including new furniture and carpets. The manager told us that when a room became vacant it provided the service with an opportunity to refresh the room before the next person came into residence. This also helped to maintain a clean environment.

We looked at staff training, staff supervision and appraisal information. There was a staff supervision schedule in place, which identified meetings during the year. Annual appraisals had either taken place or where scheduled for after the date of the inspection. Supervision sessions for care staff were conducted by the registered manager or deputy manager. We verified this by looking at the notes of staff supervision meetings and speaking with staff. Staff told us they received supervision on a regular basis, which they found useful. We saw that the frequency of supervisions was in accordance with the schedule identified in the supervision policy.

Staff were subject to a formal induction process and probationary period. One staff member who was a nurse said, "I had to complete an application form, then I had an interview and was offered a job. When I started I had a period of induction I shadowed another member of staff and my knowledge was tested out during this time. I got to know the residents and I was observed several times administering medicines before I was deemed competent to administer them myself. I did a series of mandatory training including safeguarding. At the end I felt that I had a good induction and it left me feeling confident and competent." Other staff we spoke with also confirmed they had been subject to this process. Care staff did not administer medicines and were not subject to this test.

We looked at five staff personnel files and saw that there were records, which referenced the successful completion of the probationary period and records of training undertaken during induction such as safeguarding, infection prevention and control and moving and handling.

Comprehensive staff training records were in place and staff had completed training in a variety of other

areas relative to their job role, such as manual handling, infection control, equality and diversity, food hygiene, caring for people with dementia, fire safety, first aid and medicines management. There was a staff training matrix in place that identified training achieved or planned. Training was discussed between the manager and staff members on an individual basis. For example one staff member told us they had requested to undertake NVQ 5 training in management and this had been arranged and was on-going.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw there had been three applications for DoLS made to the supervisory body prior to the date of the inspection. The registered manager showed us records that demonstrated they had followed-up the status of the outstanding DoLS applications and this was recorded in a DoLS file. Records in this file corresponded with information in people's care files.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the service was complying with the conditions applied to the authorisations. Where applications had not yet been authorised, peoples' care plans contained information which ensured that the least restrictive practice was being followed. Where people required the use of a bed rail, due to being at risk of falls, we saw that consent to use these had been obtained from the person or their relative, if they lacked capacity.

Staff told us they had received training in MCA and DoLS and most were able to explain the principles of this legislation to us. Appropriate supporting policies and procedures were in place, for example, the service had policies on MCA/DoLS and safeguarding adults. We checked the training records and saw that 75% of care staff and 100% of nursing staff had completed training in MCA/DoLS. Other ancillary staff who were not employed in a care giving role such as domestic staff had also completed this training.

Staff were aware of how to seek consent from people before providing care or support and told us they would always ask before providing care. Staff told they would ask people again later if they had initially refused care. We saw people had mental capacity assessments in their care plans, which were up to date. One staff member said, "If people have given their consent to receiving care it will be written in their care plan, but you must always ask a person before doing something each time." A second staff member said, "Though consent is written in people's care files, you must never do anything without asking them first."

During the inspection we observed the lunchtime. The dining room tables were nicely laid with table cloths, napkins and condiments. Adapted cutlery and plate guards were used by some people as identified in their care plan, which helped them to maintain their independence. There was a calm and unrushed atmosphere and people were asked before their meal what they would like to eat, in case they had changed their mind. Staff wore personal protective equipment such as gloves and aprons The service had achieved a food hygiene rating score (FHRS) of four.

Fridges and freezers were well-stocked in addition to a plentiful supply of dry and fresh food goods. There

was a four week rolling menu cycle, which was displayed both inside and outside of the dining room. People who used the service could choose an alternative meal option on any day if they wished. Vegetarian options and specialist diets were also available. Fresh fruit, drinks and snacks were also provided in between meals.

Special diets were catered for, food allergies were recorded and people had nutrition and hydration care plans in place. Information on different diet types, such as a soft diet, had been sought from the speech and language therapy team (SALT) and this informed the kitchen staff how to prepare and serve these types of foods. Advice from SALT had also been provided regarding thickened fluids. We found that this advice was being followed.

Food temperatures were recorded at each meal before serving. We observed staff taking food to people who wished to stay in their room on nicely presented trays that helped to make the food look inviting to eat. When they had finished eating staff confirmed that this was the case before removing the tray and asking them if there was anything else they wanted. We saw that one person requested second helpings and this was provided.

We asked people and their relatives about their opinions of the food. Comments received from people's relatives included, "[My relative] doesn't eat much but yesterday they changed the menu and made scrambled eggs which was what [my relative] wanted," and "Another good example of the quality of care here is when my daughter and I once visited at lunchtime as this was the only time we could come. Though I know meal times are protected they allowed us to have a meal with [my relative] and told us 'this is what would happen if [my relative] was at home, so why not here.' I can't fault it, I think they are outstanding in their commitment and professionalism," and "The food here is superb, the menus are good and nutritious, and there are always drinks available. Staff write [my relative's] food intake down as well as doing daily cream charts."

People who used the service also commented positively about the food. Comments included, "One day I saw someone having bacon and eggs so I changed my order and had a bacon sandwich – it was great," and "The menu is on the board, I can choose what I want and most of the time it's good, though sometimes the meat is a little tough for me," and "The food is lovely; I've been following a diabetic diet and it's always well cooked and fresh every day," and "The food is definitely good, sometimes there's too much. The chef makes a wonderful cherry pie and I had three helpings yesterday."

Good

Is the service caring?

Our findings

We saw staff showed patience and encouragement when supporting people. We observed people were treated with kindness and dignity during the inspection. Care staff addressed people in a respectful manner, for example at the lunch time meal we saw staff gently encouraging people to eat their food.

A person who used the service said, "The staff here are absolutely great. I've said to one staff member that if I get well I'll propose to her. My skin is checked every day so it's in good condition." Another person told us, "It's very nice here and I can't fault it. I like my door to be open but staff still knock on it before coming in." A third person said, "Staff assist me very well, even when putting your vest on they get it the right way round. Any assistance is done with respect. I used to say sorry when I had my pad changed but staff reassured me that it was all okay and it was their job to look after me. They do it with dignity and respect; there's no bad practice here."

People's relatives told us they felt staff were caring when assisting their relative. One relative said, "Staff are always helpful and pleasant, they always say hello and are genuinely interested in [my relative.] A second relative told us, "Staff are always checking on [my relative.] It's like a home from home and I'm glad [my relative] is here."

Staff spoken with had a good understanding of how to ensure dignity and respect when providing care and support and people we spoke with confirmed that they felt staff respected their privacy and dignity and promoted their independence. One staff member said, "You have to talk to people about why something needs doing and explain it first, good communication is a key element." A second staff member told us, "If I'm providing personal care I always make sure the door is closed and the curtains as well. I cover the parts of the body up that aren't being washed and always encourage the person to do as much for themselves as they can do to help them to keep their independence." One person told us, "When staff assist me they do it with dignity and respect and there's no bad practice here. My clothes are always clean; staff ask me what I want washing and it's done straight away. They've never failed me yet and I've nothing to worry about, and I feel as safe as I've felt for a long time." A second person told us, "Staff are always very respectful; they have a good attitude and promote my independence. I have no worries and I know staff would answer me truthfully if I had any concerns."

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights though suitable person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they needed to lead fulfilling lives, which met their individual needs.

We saw that the care staff knocked on people's bedroom doors and waited for a response before entering. We saw that people living at the home were well groomed and nicely presented and we overheard staff talking to people about what they wished to wear that day.

Throughout the course of the inspection we heard lots of chatter between staff and people and there was a positive and homely atmosphere within the home. Staff interacted with people throughout the day and it was clear that they had a good understanding of the individual people who used the service. We observed many occasions where staff spoke privately on a one-to-one basis with people.

People's care files contained end of life care plans, which documented people's wishes at this stage of life where they had been open to discussing this. Staff told us they involved families when developing care plans or carrying out assessments. The people we spoke with living at the home and their visitors confirmed this was the case. At the time of the inspection no person was in receipt of end of life care and each care file had a section about advanced decisions. Where people had made an advanced decision regarding end of life care this was recorded correctly, dated and signed appropriately.

Peoples' spiritual needs were accommodated through the regular attendance at the home of different faith groups. We looked at records of residents and relatives meetings, which were held regularly. Records were kept of each meeting and notes were given to people and their relatives. Recent discussions included activities, meeting spiritual needs, housekeeping, the garden area, food, staff approach and attitudes.

Good

Is the service responsive?

Our findings

We observed staff were patient, respectful and friendly towards the people who lived in the home. A family member told us, "When we first contacted the home the manager showed us round and introduced us to other residents. I got positive feedback from the people I spoke with and we were shown a room that had been identified for [my relative.] We got a service user guide that I could show to [my relative] in advance and we sat down and discussed [my relative's] care needs in advance. Nothing seems to be too much trouble, staff are friendly and communication is excellent."

Another relative commented, "I'm absolutely delighted with the staff here, they celebrated [my relative's] birthday when they were 90. When I rang the home about a potential placement they came to see me straight away which made me feel they have nothing to hide. [My relative] recently had a problem with their hearing aid and they (the service) got onto it straight away and brought in the hearing specialist." A person told us, "The staff talk to me all the time about my life and if I was at home this wouldn't have happened. They're also good with confidentiality."

Care files were well organised and contained care plans that covered a range of health and social care support needs. This included information on mobility support, activity preferences, people's social histories, sleep, dressing and personal preferences and getting out and about. We saw that prior to any new admission a pre-assessment was carried out with the person and their relative(s). One person told us, "When I first came in I had an assessment and I had a hearing test yesterday so I'm getting new hearing aids. I've also had a podiatrist visit."

People's needs for support were carefully described on their care plans so care staff knew exactly what tasks to undertake. A relative said, "[My relative] suffered from water infections when living at home which the service knew about. One day a sample was taken, the GP contacted and a prescription was sent the same day, so I was really reassured with this."

We saw detailed personal profiles in the care records, which included people's life story, their memories, risk assessments and relationships. This meant staff had information to ensure people's care was as personalised as possible. The staff we spoke with understood the contents of the care plans, knew people's needs and preferences and we saw diary sheets were updated several times during the course of the inspection.

The home employed an activities coordinator who was unavailable at the time of the inspection and there was an activities lounge in which people could undertake a variety of activities. We saw people had a choice of activities to stimulate them and activities previously undertaken were recorded in people's care files. These included arts and crafts, reminiscence, music therapy, bingo, quiz, word search and puzzles, external entertainers, and one-to-one pamper sessions. Special occasions such as Christmas, Halloween and Harvest Festival were also celebrated. A hairdresser visited every week and we saw several people using this service at the time of the inspection.

During the inspection we saw several people were reading a variety of newspapers, some were completing quiz words and some were knitting. This was in connection with the home's charity appeal which was for an orphanage in Kenya and people had been busy making blankets, bobble hats and babies matinee coats to donate to the charity. One person said, "Now were doing knitting, it's great."

The service produced a quarterly newsletter for people and their relatives. This included information about activities past and present in addition to more general information. One relative told us, "I'm impressed with the amount of stimulation that's going on especially for people with limited mobility." Another relative told us, "The activities coordinator is outstanding. [My relative] made gift cards for Christmas and residents also made a Christmas crib. Staff go that extra mile doing things like painting people's nails. I noticed the rotary club had visited and one day there was a communion service that staff encouraged [my relative] to attend and this has helped her to get her confidence back. [My relative] had recently lost weight and was referred to the dietician straight away. I sat with the nurses to do the care planning and I always know when things are happening."

Residents and relatives meetings were held usually bi-monthly and information from these meetings was used to inform the delivery of the service. People we spoke with and their relatives told us they had attended meetings about the menu, activities and special events. We saw records from the previous three meetings that verified this. Information about upcoming events was displayed on a resident's notice board, which also held information about complaints, fair access to care services, advocacy and eye care services. A charity notice board recorded that the home had previously raised several hundreds of pounds for the royal British legion poppy appeal.

People's care files identified that individuals and their relatives were involved in the planning of their care, and personal preferences were discussed. The care records showed regular visits from relevant other professionals such as a GP, optician, chiropodist and advanced nurse practitioners. This meant appropriate healthcare professionals were accessed when people required them. Each person had a detailed care pathway, an assessment of possible risks and a description of the person's needs for support and treatment. For example one person's care records stated, 'When lying on the back, please ensure the left arm is supported on a pillow when lying in bed,' and there was a picture on the person's bedroom wall to identify the required position to staff. Care plans were reviewed monthly by the senior carer or registered manager and relatives confirmed they were kept informed of any changes in their relative's needs.

We looked at how the service managed complaints and we found that the home had procedures in place to receive and respond to complaints. There was a complaints policy and procedure in use and this was up to date. We observed the compliments and complaints file and saw that issues were responded to in a timely manner. People we spoke with told us they had never had to raise a complaint, but would feel comfortable doing so if required. One person told us, "I've nothing to worry about at all." A second person said, "I've never had to complain about anything." A relative commented, "If I had any concerns I would gladly tell you, but I haven't got any. You get a feel for a place and I've never had any qualms about anything going on behind the scenes here."

Good

Is the service well-led?

Our findings

There was a registered manager at 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.

People who used the service and their relatives spoke positively about the management team. One person said, "I think staff and management are very competent and they assist me very well and I feel as safe as I've felt for a long time." A relative told us, "I have no issues with staff or managers that I have been worried about." A second relative commented, "The manager is always available and looks after us all the time. I feel they genuinely care and if they are concerned the manager always rings me; very approachable and very good."

Staff said they liked working at the home. They told us they thought the home was well led and said that the registered manager was approachable and fair. One staff member told us, "I feel very well supported by the manager and would feel confident in raising an issue with them." A second staff member said, "I enjoy working here and feel confident I would be listened to if I had any concerns. I have spoken with the manager about issues before and they responded straight away. I think the service is well-led and I would recommend it. The manager is good at listening and supporting personal issues." A third staff member commented, "The culture is lovely, we get a lot of good feedback about what we've done and the manager is supportive which gives me confidence."

We reviewed documents, which the service used to monitor the quality of its service by seeking feedback from people who used the service, their families, staff and visitors. We found that residents' meetings had been held regularly. Records of these meetings were detailed and showed that various issues had been discussed. The service held a meeting for people who lived in the home approximately once every two or three months, which included their relatives. This provided an opportunity to discuss any concerns and encouraged suggestions to improve the home and the care provided. Feedback recently received was overwhelmingly positive and complimentary.

We saw the registered manager carried out a number of audits within the home, including safeguarding referrals, complaints, care plans, health and safety and the management of medicines and the environment. The manager also carried out a daily walk-around of the entire premises. We saw evidence of action plans that the manager used to improve care or practice. Observations of medicines administration practice had also been carried out, which staff verified.

We saw evidence of recent staff meetings in September, October and December 2016 where discussions included accidents/incidents, team working, the nurse call system, activities, infection control, staff rotas and training.

Staff supervisions were undertaken regularly and we saw that these were used to discuss issues on a one to

one basis. Staff appraisals were carried out annually and were used to look at progress made, training needs and goals for the future. There was a staff supervision planner in use and this identified planned and actual dates for meetings for the whole year through to December 2016. The frequency of meetings was in accordance with the home's supervision policy.

There was a business continuity management plan in place that identified actions to be taken in the event of an unforeseen event such as the loss of utilities supplies, loss of the telephone system, supplier failure, epidemics and pandemics (such as flu) and flood and fire. The home also submitted monthly information using the NHS Safety Thermometer. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.

Throughout the course of the inspection we saw the registered manager walking around and observing and supporting staff. We saw that the registered manager was very visible within the home and actively involved in provision of care and support to people living at Lakeside.

The service worked in partnership with a wide variety of organisations and professionals including local faith groups and local schools, doctors, dieticians, speech and language therapists, social workers, Wigan and Leigh Hospice, podiatrists, urologists and consultants as required.

There was a full range of policies and procedures in place which were available in paper copy format and electronically. These covered all areas of care provision as well as providing specific guidance and safe systems of working in relation to use of equipment.

Accident and incident forms were completed correctly and included the action taken to resolve the issue. The service appropriately submitted Statutory Notifications to the Care Quality Commission (CQC) as required and had notified the CQC of all significant events, which had occurred in line with their legal responsibilities.

Staff and managers understood their role in sending notifications to CQC and had sent us notifications as required by the regulations. People's care records were kept securely and confidentially, and in accordance with legislative requirements.

There was a service user guide and statement of purpose in place. A statement of purpose is a document which includes a standard required set of information about a service. When people were given a copy of the service user guide they were also given a copy of the complaints policy, a satisfaction questionnaire and terms of residence.

There was an up to date certificate of registration with CQC and insurance certificates on display as required.