Arms Associates Limited

Laburnum Lodge

Inspection Report

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Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 2 April 2014. A breach of legal requirements was found. As a result we undertook a focused inspection on 3 September 2014 to follow up on whether action had been taken to deal with the breach.

You can read a summary of our findings from both inspections below.

Comprehensive inspection of 2 April 2014

Laburnum Lodge is a care home which provides accommodation and care for up to 22 older people, some of whom have a diagnosis of dementia. The home does not provide nursing care.

We saw that staff were able to deal with an incident in a way that kept the person safe and dignified. However this highlighted that there were not enough staff on duty in the areas within the home to ensure all other people were kept safe.

We heard staff talk with people in a pleasant and encouraging tone, and used the name the person wanted to be called. There were some terms of endearment, but it was evident that people in the home were very happy with that.

There were many visitors on the day of inspection, some of whom stayed for lunch. It was obvious that this was a normal occurrence and meant relative's were encouraged to visit and stay for meals.

There was a new computer system where care plans and risk assessments were written and recorded for people living in the home. The system was word protected which meant people could be assured their information was kept safe.

Although there was evidence that staff had undertaken training such as moving and handling, fire safety, safeguarding and infection control, some competency and skills based training, such as medication, had not been completed. This meant staff responsibilities to deliver care to people safely and to an appropriate standard was not always met.

There were other training courses that had been undertaken by staff, such as dementia and whistleblowing, which meant their learning and development enabled them to provide effective care to people in the home.

The manager said there was no system in place to check the correct levels of staffing necessary. This meant that there were not always be sufficient numbers of suitably qualified and experienced staff on duty.

The service did not always follow current and relevant professional guidance about the management of medicines, and staff did not have sufficient training to enable them to manage people's medicines safely.

There was an annual system in place to assess and monitor the quality of the service by seeking the views of people who live in the home or their relatives and other professional.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS), and to report on what we find. (The deprivation of liberty safeguards are a code of practice to supplement the main Mental Capacity Act 2005 Code of Practice.)

We looked at whether the service was applying the Deprivation of Liberty safeguards (DoLS) appropriately. These safeguards protect the rights of adults using service by ensuring that if there were restrictions on their freedom and liberty these would be assessed by professionals who are trained to check whether the restriction was needed. While no applications had been submitted, proper policies and procedures were in place but none had been necessary. Relevant staff have been trained to understand when an application should be made, and in how to submit one. We found the home was meeting the requirements of the Deprivation of Liberty Safeguards. People's human rights were therefore properly recognised, respected and promoted.

Focused inspection of 3 September 2014

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory

Summary of findings

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 and to look at the overall quality of the service.

This inspection was unannounced, which meant that the provider did not know that we were coming. The purpose of this inspection was to check whether the provider had met the requirements of the compliance actions we had issued following our inspection on 2 April 2014. We had issued compliance actions because there had been breaches of four regulations.

The provider sent us an action plan and told us they would be compliant with all the regulations by 18 July 2014. We returned to the care home on 3 September 2014 to check that the provider had taken action to address the concerns we had raised previously.

Laburnum Lodge is registered to provide accommodation and care for up to 22 people. The care home provides a service for older people who have physical care needs and for people living with dementia. There were 12 people living there when we inspected on 3 September, one of whom was in hospital.

At the time of our inspection the person managing the care home had been in post for about four weeks and had not yet submitted an application to the Care Quality Commission to be registered as manager. This meant there was no registered manager in post.

We found that improvements had been made in the way people were cared for. People and their relatives were happy with the service they were receiving and we heard many positive comments about the service, the new manager and the staff team.

However, we found that the quality monitoring tool introduced by the provider was not sufficiently robust to give assurance that a good quality service was being provided. Some of the records required by the regulations were not being adequately maintained.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

2 April 2014

People living in the home and their relatives told us that most of the time there were enough staff on duty to make sure people were cared for safely. However, we saw that unforeseen circumstances, as well as day to day requirements meant there were times when there were not sufficient staff to ensure all areas within the home kept people safe.

We found that although improvements had been made since our last inspection, the service was not consistently managing medicines in a safe way. The service did not always follow current and relevant professional guidance about the management of medicines, and staff did not have sufficient training to enable them to manage people's medicines safely.

Care plans and risk assessments were updated where necessary which meant people were protected from the risk of harm.

The home had proper policies and procedures in relation to the Mental Capacity Act and

Deprivation of Liberty Safeguards although no applications had needed to be submitted. Staff had been trained by the local authority to understand when an application should be made, and in how to submit one. This meant that people would be safeguarded as required.

3 September 2014

People we spoke with said they felt safe at Laburnum Lodge, because they had confidence in the staff team.

Improvements had been made in the way staff handled medicines. Medicine administration records had been completed as required, which showed that people had been given their medicines safely and as prescribed.

On the day of our inspection there were sufficient staff on duty so that an unforeseen incident was managed well. However, staff rotas showed that there had been an occasion when there had been fewer staff on duty than the minimum level the provider had stated was required.

Are services effective?

2 April 2014

Summary of findings

People's health and care needs were assessed and they were involved in writing their plans of care. Specialist dietary, mobility and equipment needs had been identified in care plans where required. People said that they had been involved in writing them and they reflected their current needs. People told us they had been involved in decisions about their care and the staff were quick to consult other health and other professionals when necessary.

People were encouraged to maintain their independence and we saw examples of this during the inspection.

Staff had received appropriate training to ensure they had the knowledge and skills they needed.

3 September 2014

People said that their care needs were met by the staff in the way that they wanted. Staff encouraged people to be as independent as possible. Staff told us about one person who, due to the care and support delivered by the staff, was continuing to improve following a stroke.

At lunchtime we saw that people were given the food they had chosen earlier in the morning, and that the meal looked appetizing and nutritious. Staff did not always tell people what was on the plate, which was difficult for one person in particular as they had poor sight.

One person's relative told us that their family member's health care needs had been fully met by the staff.

Are services caring?

2 April 2014

People told us that staff were very caring and relatives said their family members were well supported by polite staff. We saw that care workers showed patience and gave encouragement when supporting people.

During an incident we observed how a person was treated with dignity and compassion, whilst awaiting the emergency services.

People had their choices and preferences discussed and provided by staff.

3 September 2014

We saw that staff interacted in a very positive and friendly way with people and took people's individual abilities into account when they spoke with them. People and relatives we spoke with told us they

Summary of findings

were happy with the service being provided at the home and how much they liked the staff. One person said, “It is excellent here. I don’t want to go anywhere else.” Another person told us, “It’s all very nice indeed. I’m very happy here.”

People told us that staff were very respectful and respected people’s choices. Visitors to the home told us how impressed they were with the service being provided by the staff.

Are services responsive to people’s needs?

2 April 2014

Although people told us their basic needs were met, there were few activities that took place in the home to encourage to maintain hobbies or provide facilities for them. People told us that the activities that had taken place were adequate. The activities co-ordinator only came to the home once a week. This meant people did not have activities available that reflected their personal choices.

There was a complaints policy but there had been no comments or complaints made about the service. All the people and relatives we spoke with knew how to make a complaint if they were unhappy.

3 September 2014

People and relatives who spoke with us were all aware of how to make a complaint and said they would feel comfortable doing so but had never had to raise any concerns.

We were told that improvements had been planned in relation to the activities that were provided for people but these had not yet been put in place. One relative told us that some of the activities that did take place were not suitable for some people and most declined to join in. On the day we visited no activities were taking place.

Are services well-led?

2 April 2014

There was a registered manager in post.

Staff were aware of their roles and responsibilities and were supported by the manager. None of the staff we spoke with had any issues or concerns about how the service was being run.

The staff worked well with other health professionals as was seen on the day of inspection. This meant incidents and accidents in the home were dealt with effectively, although these were not always used to monitor and inform practice.

Summary of findings

There was an annual questionnaire so that people living in the home were able to express their

views and opinions about how the service was being run. However the minor changes needed took seven months to be addressed.

There was no effective method used by the manager to ensure that were sufficient number of staff, with the right competencies, knowledge, qualifications, skills and experience to meet the needs of people living in the home.

Audits and checks in relation to medication and staffing levels for example were not completed.

3 September 2014

Since our inspection in April 2014 there had been changes in the day-to-day management of the service. The registered manager had left and the new manager had been in post for four weeks at the time of this inspection.

People we spoke with, relatives and staff all made positive comments about the new manager. People felt she was interested in them and concerned about their well-being. Staff felt supported and listened to.

The provider's electronic record-keeping system was not fully accessible by the staff on duty on the day of our inspection and there was no system in place for keeping a record of people's appointments with other health care professionals.

Staff rotas were not accurate and did not give a complete account of which staff had been on duty and when.

Since our last inspection in April 2014 the provider had introduced an audit tool so that they could monitor all aspects of the service and ensure that a good quality service was being provided. This tool was not robust enough to evidence that quality monitoring had taken place.

Summary of findings

What people who use the service and those that matter to them say

2 April 2014

We spoke with eight people living in the home, and seven relatives who were visiting on the day of our inspection. All the relatives we spoke with told us they were happy with the care their family member received. One relative explained: "They were so friendly to my mum that she has stayed here since her first visit". Another relative said her mother was treated well, saying, "Yes, treated kindly".

One relative we spoke with said that the staff always contacted the relevant health professionals for their family member and then informed them (the relative) immediately afterwards. One relative said: "He always sees the GP, chiropodist and they even called the ambulance. They call anyone out, even on a Sunday".

One person said; "They (the staff) are all nice, I have nothing bad to say about them".

People said they felt the staff were very busy and rushed. One person said: "They don't have time to do talking. The cleaner may talk to me sometimes, and does my bed."

One relative summarised the care saying: "I find the staff very good, I'm just happy all the way round. If there was anything wrong I would complain, they're all very friendly".

Laburnum Lodge

Detailed findings

Background to this inspection

This inspection report includes the findings of two inspections of Laburnum Lodge. We carried out both inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspections checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and looked at the overall quality of the service, under the Care Act 2014.

The first was a comprehensive inspection of all aspects of the service and took place on 2 April 2014.

This inspection identified a breach of regulations. The second was undertaken on 3 September 2014 and focused on following up on compliance actions from our inspection on 2 April 2014. You can find full information about our findings in the detailed key question sections of this report.

2 April 2014

We visited the home on 2 April 2014. This inspection was unannounced which meant the provider and the staff did not know we were coming. Our inspection team was made up of an inspector, a pharmacist inspector and an expert by experience who had an understanding of dementia care.

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

Prior to our inspection we reviewed historical data we held about safeguarding incidents in the home and reviewed incidents that the provider had informed us about.

During the inspection process we talked with eight people living in the home, seven visitors, three staff, and the registered manager. We looked at four people's care plans and other documents.

At our last inspection in February 2014 we identified problems in relation to medication. The provider sent us an action plan in March 2014 telling us how they would address this. We looked at medication during this inspection and the necessary improvements had not been made.

3 September 2014

This inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spent time observing how people were being supported and we watched the meal time experience at lunchtime. We spoke with 11 people using the service, three relatives, two members of staff, the acting manager and the provider's operations manager.

We looked at a range of records, including the care records relating to two people; staff rotas; medicine administration records; and the provider's auditing tool.

Action we have asked the provider to take as a result of this inspection can be found towards the end of this report.

Are services safe?

Our findings

Findings from the comprehensive inspection of 2 April 2014.

People we spoke with said they felt safe and relatives who visited at the time of the inspection agreed. People were safe because safeguarding procedures were in place and staff understood their roles and responsibilities to ensure people in the home were protected. Staff told us they had undertaken training in safeguarding and there was further evidence on the training matrix. Staff said they had attended a course with the local authority and were able to discuss what constitutes abuse and what they would do to raise concerns. All three staff we spoke with said there were clear policies and procedures in the policies and procedures file. They all knew where the telephone numbers for the local authority safeguarding team and other relevant numbers could be located.

There was not an effective system in the home for staff to manage and record accidents and incidents. During the inspection there was an incident when someone fell from their chair. Staff immediately responded and checked the person for any injuries, kept the person comfortable and dialled 999. They then ensured the person's privacy by using a screen to shield them from other people in the home. The incident took place in the dining area and there were no staff present at the time, but the inspector was able to summon help. Once staff arrived one member of staff was occupied with the person who had fallen out of a chair. Another person wanted to leave the home, and was trying to find a way out, which also required staff assistance. There were three staff members and the manager in the home. This meant if anyone required two staff to assist with hoisting, there were no staff to help other people. This meant there were not always sufficient staff on duty to make sure they could respond to unforeseen events. This meant there had been a breach of the relevant legal regulation (Regulation 22) and the action we have asked the provider to take can be found at the back of this report.

The number of staff on duty were detailed on the rota. It showed that there was one senior and two carers all day and at night there were two waking carers. The manager said extra staff would be provided when necessary. For example if a person in the home was unwell or needed to attend a hospital appointment. There was evidence on the day of the inspection that an extra member of staff took one person to hospital for an appointment and other staff confirmed this. Staff told us that holidays and sickness were covered by other staff working at the home. This was confirmed by the manager, who stated that there were no agency staff employed.

Staff we spoke with were able to tell us about how they would deal effectively with a person who displayed difficult behaviour. They commented that there were currently no people in the home who had serious challenging behaviour. One member of staff explained how they manage situations. For example, one person in the home can be reluctant to take medication and becomes agitated. They told us how they encouraged the person to take their medication by talking with them and sitting at their level, explaining what the medication is for and that although they don't have to take it they should think about it. The person usually agrees to take the medication. Another person does not like help with their personal care. The member of staff sings with them and as a result the person sings and continues, with assistance, to wash and dress.

While no applications had been submitted, proper policies and procedures were in place but none had been necessary. Staff had been trained by the local authority to understand when an application should be made, and in how to submit one. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards.

At our last inspection in February 2014, we found a number of issues with the way medicines were managed which meant that safe and effective arrangements were not in place to ensure that people were receiving their medicines as prescribed.

The provider wrote to us on 27 March 2014 stating that they had taken action and had made the necessary improvements by 7 February 2014.

At this inspection, we found a policy for medicines to be used "when required" or "PRN", and written guidance was now available to enable staff to administer these medicines correctly. Although most people were unable to manage their own medicines, one person was being supported to self-administer prescribed creams. A risk assessment had been written and secure storage had been provided in their room.

Although improvements had been made, we found that medicines audits had not been carried out by the manager

in sufficient detail to ensure the safe administration of medication. The manager was aware that the audits were not comprehensive, but had not taken action to address this.

We found that the service did not always follow current and relevant professional guidance about the management of medicines. All prescribed medicines were available in the home but topical medicines, such as creams, were not being used as prescribed. We found prescribed creams in people's rooms which did not appear on their current medicine administration records (MAR). Some creams were overstocked, some were without labels or date of first opening, and for some prescribed creams there was no record of use. This meant there had been a breach of the relevant legal regulation (Regulation 13) and the action we have asked the provider to take can be found at the back of this report.

We saw that the full details of Controlled Drugs administered to people were not always recorded in the Controlled Drugs register. This meant people may not have received the prescribed medication required.

We noted that some staff had added handwritten medication details to people's printed MARs. We saw that no checks had been carried out to ensure that instructions for these medicines had been transcribed correctly. We also saw that staff had handwritten records when some medicines were changed or stopped. However, it was not possible to identify which member of staff had made these changes as the amendments were not always signed and dated. This meant there had been a breach of the relevant legal regulation (Regulation 13) and the action we have asked the

provider to take can be found at the back of this report.

We saw records of fridge temperatures that showed for a period from October 2013 medicines, which included insulin, had not been stored at the correct temperatures to remain fit for use. The manager told us that the insulin had not been administered to anyone as the person, who had been on respite care, had been taken into hospital; however other medication such as antibiotics had been stored in the fridge at that time.

Although staff had received half a day's medication training, the manager had not carried out any formal competency assessments before allowing staff to administer medicines to people. This put people at risk from staff who did not have the appropriate skills to manage medicines. This meant there had been a breach of the relevant legal regulation (Regulation 23) and the action we have asked the provider to take can be found at the back of this report.

Staff told us that there was no-one in the home that did not have capacity. The manager said that there was one person who may need an assessment under the Mental Capacity Act (MCA) in the future but the person was still able to make decisions at the moment. This meant people's capacity was considered under the MCA.

They said that all those people living in the home had families who acted on their behalf. The manager stated that there were three people whose family had Enduring Power of Attorney, but there was only one family that had provided a copy of the document. The provider may find it useful to note that the manager was not aware of other support agencies such as Age UK, Parkinson's Society and Independent Mental Capacity Advocates (IMCA) who could act on people's behalf, although staff told us that there was information available should anyone request an independent advocate and were able to offer examples of those services.

Findings from the focused inspection of 3 September 2014

People we spoke with told us they felt safe at Laburnum Lodge. One person told us the staff were good at their jobs, which gave this person confidence and made them feel safe. Other people said they could move around the home safely. A visiting relative told us they knew their family member's needs were met.

During our inspection on 2 April 2014 we found a number of issues with the way medicines were managed, which meant that safe and effective arrangements were not in place to ensure that people were receiving their medicines safely and as prescribed. The provider wrote to us and told us they would be compliant with the relevant legal regulation (regulation 13) by 23 June 2014.

At this inspection we checked the way people's medicines were managed and found that improvements had been made. We checked six people's medicine administration record (MAR) charts. Staff had completed all the records correctly by adding their signature to show that each dose of medicine had been given, or if not given, the reason why not. The MAR charts included signatures to show that

Are services safe?

creams had been applied as prescribed. We checked that the number of medicines remaining in their original packets tallied with the records. We checked eight medicines and all were accurate.

The provider had kept a daily record of the temperature of the fridge where medicines, which needed refrigeration, were kept. We saw that all the temperatures fell within the recommended range of temperatures so that the medicines remained fit for use.

We checked the record of controlled drugs (CDs). Although improvements had been made, the record was not accurate. There were two entries on the record, which showed that there should have been two medicines in the CD cabinet. There were no drugs in the CD cabinet and the staff member assisting us confirmed that no CDs were currently in use.

At the time of our inspection there were only two members of staff who were trained to administer medicines: a third staff member had left the previous weekend. The manager was aware that this was not enough and had recruited a new member of staff who had been trained by their previous employer. This meant that there would be a staff member who was trained to assist with medicines if either of the two existing trained staff were not available.

Senior staff told us that two care workers were being trained to administer medicines: one had been shadowed to give people their medicines on the day we inspected.

The manager told us that these staff had undertaken training to administer medicines and we saw evidence that staffs' competence to administer medicines had been assessed by the manager.

On 2 April 2014 we found that there were not enough staff on duty to respond to unforeseen events. The provider wrote and told us that there would be an adequate number of staff on duty at all times, by 18 July 2014. They stated that they would ensure there was 'a senior and two staff members on each shift at all times'.

On the day of this inspection we found there were four staff on duty, which meant there were sufficient numbers of staff on duty to ensure that people's needs were met. When we arrived at the home an emergency ambulance was in attendance as one person had been taken ill. There were enough staff on duty so that two staff stayed with the person to support them while they waited for the ambulance, and assisted the paramedics with information about the person. Both ambulance crew were impressed with the staff. One described them as "spot on".

However, when we looked at the staff rotas for the previous week we saw that on one day there had only been two members of staff on duty, which was below the minimum level that the provider had assured us they would retain. This meant there had been a risk that people's needs would not be met and people would not be kept safe.

Are services effective?

(for example, treatment is effective)

Our findings

Findings from the comprehensive inspection of 2 April 2014

People's needs were assessed and their support and care was planned and delivered in line with their individual plans. Two relatives knew about, and had been involved in, writing the care plan for their family member. Information on three of the four care plans we looked at showed the person or their relative had been part of the process. This meant steps were taken to involve people and their relatives in making decisions about their needs. The manager stated that there was no available record in the new care planning system, which was now on computer, for people to sign they have been involved. We discussed other options to evidence the fact.

Staff we spoke with said they were able to meet the needs of the people living in the home. They were aware of people's care plans and the support each person needed. They told us they were not involved in writing the care plans but if they noted any changes in a person's health or wellbeing they knew who to speak to and ensured the plan was changed. This meant people's plans were kept up to date and staff had information that was current.

Examination of a sample of four people's care records showed that their health was maintained and promoted. People who used the service were supported to access a range of health care services. People we spoke with, and their relatives, told us they had input from a variety of health professionals including their general practitioner (GP), district nurse, dietician, chiropodist and hospital staff.

We looked at people's care records, and information provided by members of staff, indicated that people's weights were monitored and action was taken if needed. This included referrals to the dietician or GP where necessary. We saw that where a dietician had requested a person be weighed more frequently, this was done. This meant people's physical health and wellbeing were monitored and actions were taken if needed.

Most people we talked with were happy with the support they received at meal times. One relative said that her mother would probably like another drink in the afternoon whilst one person said they would like a fresh drink in the afternoon. This person was not happy with her meals and said: "The meals are always cold by the time they get up here". We observed staff during the day and heard them ask people if they wanted drinks or snacks. We fed back to the manager about the meals being cold when they arrived in one person's room and were told it would be dealt with. Minor improvements were needed so that people had fresh drinks available at all times.

We saw that people living in the home and their families had been encouraged to detail information to support their individual end of life wishes. The manager said that any equipment or extra staff would be provided when necessary. People living in the home did not have any concerns about staff training and made some complimentary comments about the staff. One person said: "Yes, they all know what they are doing". The relative of a lady with complex physical disabilities said: "I think they deal very well with her". We looked at training records which showed staff had received appropriate training. Staff we spoke with told us about their training and that the majority of updated training was provided on the computer.

In discussions with people about whether staff understood and knew them, we found that people who were more able thought they were catered for quite well. One family member said about her relative: "They know what he likes and what he doesn't like, they look after him really well".

There were some people with dementia who were not engaged. We saw records that showed all staff had received training in caring for someone with dementia. The manager explained that the staff were in the process of compiling a, "This is my life" book for each resident living with dementia. Staff we spoke with said they would be completing the books with the person and their family as soon as possible and that it would provide a better understanding of the person. Minor improvements were needed so that all those who lived in the home were engaged.

We observed that people were supported with equipment to be independent, and this was done safely and with respect to people's dignity and privacy.

Findings from the focused inspection of 3 September 2014

People we spoke with told us that the care and support they needed was delivered by the staff in the way they wanted it to be. One relative was very pleased with the

Are services effective?

(for example, treatment is effective)

service being given to their family member who had complex health needs. They told us that staff spent time trying to encourage their family member to accept the care and support they needed.

One staff member described how one person had improved following a stroke. The staff member believed this was due to the care and support delivered by the staff and they were visibly pleased and excited about the person's progress.

We watched the way that lunch was served to people and the way staff supported people who needed support with their meal. Earlier that morning people had been offered a choice of what they wanted to eat and the food was presented on the plate in an appetizing way. When the food was served we noticed that staff did not tell people what was on the plate. This meant that people who were forgetful or had poor sight did not always know what they were about to eat. One person was shocked when they took a mouthful of their pudding and found it was ice-cream and not the warm rice pudding they were expecting.

Staff showed us that food and drink monitoring records were completed for people when an issue with their nutrition or hydration, such as weight loss, had been identified. The records enabled staff to ensure that people had a sufficient amount to eat and drink.

People told us that their health needs were met by the staff. One relative said that staff had noticed that their family member, who was reluctant to see a dentist, had a problem with their teeth. Since then, staff had been trying to encourage this person to see the dentist. Staff had been persistent in following up the results of blood tests for this person, which had not been returned by the hospital. Due to the staffs' persistence, this person had been prescribed a new medicine, which had made a big difference to their health and wellbeing. This meant that staff had effectively met this person's health care needs.

Are services caring?

Our findings

Findings from the comprehensive inspection of 2 April 2014

People we spoke with, and their relatives, told us they were very happy with the care they received in the home. One relative said: "Staff do a brilliant job". One person living in the home said: "It's lovely here. I couldn't wish for better." One relative said, "They're very polite, as soon as I got here the staff got me a cup of tea".

One person said the staff were: "…smashing". People we spoke with told us they were treated with respect and dignity by the staff. One person said, "Yes they always do" – referring to being treated with respect. One relative said: "I come regularly and have seen that people are being treated with respect". We heard people being addressed in the way they wish to be. One relative said: "He likes to be known as X and staff always speak to him using his name". Another person told us that when their relative visited the home, staff asked them where they would like to spend time. Most of the time the person chose to take their relative into their bedroom which they said showed a regard for their privacy and dignity. During the inspection we heard how people were asked their choice of meal, drinks and day to day preferences. Staff were able to tell us how they provided choice for people to ensure their independence was maintained as far as possible. This meant people were offered and given individual preferences.

Care and support was centred on each person. It was evident through our observations during the inspection that staff were caring and knowledgeable about each person and their individual ways of working with them. The staff responded and understood people and were able to meet people's needs. Staff were able to tell us how they communicated with people and that there were different methods available, such as pictorial information, should that be necessary. They all said that people in the home managed to convey their requirements verbally and by body language so have not had to use other methods.

Kindness, respect, dignity and compassion were evident in the incident that occurred during the inspection. Staff laid down on the floor with the person so as to be able to communicate with them. They used a screen to keep the person's dignity and respect. The staff ensured the person was comfortable using duvets, pillows and blankets until the paramedics arrived.

Information provided by the staff and in the paperwork available ensured that people had the necessary information with them to take to hospital. We saw that staff supported people for appointments to hospital and in emergency situations. One person confirmed that they were always accompanied by a member of staff for hospital appointments.

Findings from the focussed inspection of 3 September 2014.

People we spoke with, and their relatives, told us they were very happy with the care and support they received at Laburnum Lodge. One person told us, "They are all very kind. I am very comfy". Another person said, "The staff are lovely, I couldn't wish for better."

We saw staff interacting with people in a very positive and friendly way. When they had a conversation with someone, staff got down to the person's level, always made eye contact with the person and showed real concern for the person's well-being.

One lady who lived at the home told us that staff "are all very respectful." This person had told us they had expressed a wish not to have male care staff to support them with their personal care and this had been noted and adhered to. One person told us that they wanted to retain their independence and that staff encouraged them to do as much as they could for themselves. This meant that staff respected people's lifestyle choices.

A regular visitor to the home, who had also had experience of visiting other care homes, told us, "This is a nice home, very caring. The staff do genuinely get to know everyone and take a real interest in them. One of the ambulance crew we spoke with when we arrived at the home said they were "dead impressed" with the home and the staff. They said, "They [the staff] know the patients really well, they really care."

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Findings from the comprehensive inspection of 2 April 2014

There was evidence in the files of the three people we looked at, that they or their relative had been part of the planning of their care and that their choices and preferences had been taken into account. All the people we spoke with were happy with how staff communicated with them and responded to their caring needs.

One relative said: "They always say if we have any complaints, just say and they will be dealt with". All the people we talked with said they knew how to complain and would complain if they wished, but no-one had done so. There had been no formal complaints made in the home.

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The manager explained that there was an activities co-ordinator who arranged activities for people living in the home; however they only came to the home once a week. Manicures were given as examples of activities for people. The co-ordinator also organised another person to come into the home to do a skittles activity. The people we spoke with mentioned that they were happy with these activities, or chose not to participate in the activities at all. Staff we spoke with said they understood the people who were living in the home and were able to meet their needs. They said that most people would tell staff if they were not happy participating in any activity, but would be offered all opportunities available. On the day of inspection we saw that there were no activities that took place. This meant there were no different types of activities to suit individual interests and needs, nor different methods to encourage or engage people with rewarding activities.

Staff said each shift was different and there were times when they would have liked to spend more time with individual people in the home. The manager said that staff did have the opportunity, once people have been assisted to get up, washed and dressed, to spend time with people. There were some people who needed assistance to eat their meals and the manager said staff were expected to ensure people were not isolated. The manager stated that there were five people in the home who chose, each day, to stay in their room. It was expected that staff would go in regularly to check people's welfare and we saw that staff went to people's rooms to take drinks and their meals. Staff we spoke with told us they visited people in their rooms to ensure they had drinks available and any meals if they wished to remain in their room. People we spoke with told us they were asked if they wished to go to the dining room for meals and to attend any activities.

Two people mentioned how quickly staff responded to people's emergency calls and requests for care. They emphasised that the staff were particularly good at this aspect of their caring role. One said: "They are there like a shot, they have done very well" and another said: "They're good at their job, when people ask for assistance they're soon there,…they are good".

Findings from the focussed inspection of 3 September 2014.

All the people we spoke with, and their relatives, told us they knew how to make a complaint if they needed to. They said they would have no problems in talking with members of staff or the manager, although none of them felt they had cause to complain.

During our inspection in April 2014 we reported that there was a lack of meaningful activities, especially activities for people based on their individual preferences. At this inspection, we were told that a volunteer member of staff came to the home a couple of times a week to lead an activity in the main lounge. However, a relative told us that the activities were not very well thought out for people with hearing and sight difficulties and most people declined to join in. No activities took place on the day of the inspection. We noted that, although staff visited people regularly to

Are services responsive to people's needs?

(for example, to feedback?)

offer food and drink and make sure they were alright, there was little stimulation for people who chose to remain in their own room. Staff we spoke with told us that they were becoming much more involved in doing activities with people, especially on an individual basis. They also said that the new manager had lots of good ideas for activities, entertainment and outings, which were being put into place. This meant that the service being provided was still not fully responsive to people's individual needs.

Are services well-led?

Our findings

Findings from the comprehensive inspection of 2 April 2014.

Laburnum Lodge has a registered manager in post.

We saw that the manager worked with the staff and was available to support them when they needed it. However we noted that the hours worked by the manager were not detailed on the rota which meant staff would not be aware of her availability. Staff we spoke with said the manager and provider were approachable and they would be able to question practice and would whistle blow when necessary, but they had not needed to do so. They said there was information, including telephone numbers, so that they could deal effectively with their concern.

The operations manager said there had been quality assurance questionnaires sent to people in the home, their relatives and professionals in August 2013. The information provided in the responses showed people wanted more areas in the home so that they could talk privately with family and friends. On the day of inspection this had not been completed. Following the inspection we received information from the operations manager that the general areas in the home had been changed and people and their families said the layout was much better. This demonstrated that although only minor changes had been necessary it had taken the provider seven months to complete.

We were told that there were no formal systems in place to monitor and assess the sufficient numbers of staff to ensure people's needs and levels of dependency could be met. This meant there had been a breach of the relevant legal regulation (Regulation 22) and the action we have asked the provider to take can be found at the back of this report.

The manager stated there were no residents or relatives meetings for people to express their views, or raise concerns on a regular basis, however, people had opportunities to speak with staff daily, and they in turn would refer any issues to her during daily handovers and staff meetings. Minor improvements were needed as there was no evidence that the meetings and handovers had taken place, nor what the outcomes were.

Governance and quality assurance systems were not effective because audits and checks were not completed adequately. This meant there had been a breach of the relevant legal regulation (Regulation 10) and the action we have asked the provider to take can be found at the back of this report.

Staff were able to tell us about their roles and responsibilities. Care staff were clear that only senior staff administered medication.

Notifications had been sent to the commission when necessary and had been completed adequately.

Staff told us about emergency situations such as a fire or other incidents. They told us there was information available such as the fire evacuation plan for each person in the home and the organisation of staff in the event of a fire.

Findings from the focussed inspection of 3 September 2014.

Since our previous inspection on 2 April 2014 there had been a change in the day-to-day management of Laburnum Lodge. The registered manager had left and at the time of this inspection a new manager had been in post for four weeks. This meant there was no registered manager in post.

The new manager told us she had many years' experience of working in the care sector, including managing a care service. People we spoke with, their relatives and the staff all made positive comments about the manager. They told us she was 'very visible' and spoke to people every day. They said the manager was friendly, interested and concerned. Staff told us she was full of good ideas and had already started to make positive changes for the people who lived at Laburnum Lodge.

The provider used an electronic system for keeping records such as people's care plans and records of the daily care they had received. A member of the provider's staff had updated all the care plans. Members of staff on duty at the time of our inspection were able to complete some of the records, and they knew where to locate some of the information about each person and their needs. However, they were not able to interrogate the system sufficiently well to find all the information we wanted to find. This

meant that the provider had not given staff sufficient training to make sure all staff could use the system competently, which in turn meant that there was a risk that people might not have received the care they needed.

We noted that people's appointments with other health care professionals were recorded in the daily notes that were written on to the electronic system by the staff. This meant that it was not possible to check, without reading back through daily notes, when people had had appointments with other health care professionals, such as an optician, dentist or chiropodist. Nor was it possible to check when future appointments were due. In the daily notes staff had written that one person required an appointment with a diabetic nurse in three months' time. Staff told us that the system did not have the facility to flag up when future appointments were required and there was no other system being used. The provider stated that all healthcare professionals reminded people when their appointments were due. Although this might have been the case, the provider had a responsibility to monitor people's health and keep appropriate records, which they were not doing. This meant that the provider was in breach of the relevant regulation (regulation 20) and the action we have asked the provider to take can be found at the back of this report.

Our inspection in April 2014 found that there was not a system in place to monitor and assess the numbers of staff required to ensure that people's needs were fully met. The provider wrote to us and told us that they would ensure there were at least three staff on duty, with the relevant mix of skills, at all times and that this number would be reviewed when more people were admitted to the home. Although there had not been any admissions to the home, the provider had not put a formal system in place to assess the numbers of staff needed to ensure people's levels of dependency could be met.

We noted, from the staff rotas, that there had been one day during the previous fortnight when there had been only two care staff on duty. This meant the provider had not staffed the service to the minimum level they had proposed. The staff rota also showed that one member of staff had worked 17 days in a row without a day off and the week before our inspection had worked 67 hours. This means there was a risk that people's care could have been compromised because the member of staff was working such long hours.

Following our last inspection we reported that the hours worked by the manager were not detailed on the staff rota, which meant staff were not aware of her availability. During this inspection we looked at staff rotas for four weeks up to and including the week of the inspection. The manager stated that she was counted in the staffing numbers as she regularly worked 'on the floor'. The manager was marked on the rota as 'office', for 17 of the 19 weekdays. On the day we inspected she had gone on a training course so was not in the building. This meant that details of the hours worked by the manager and her availability were still not being recorded.

We saw a number of entries on the rotas that were not clear. For example, some staff were on the rota to work '7-9pm'. It was not clear whether this was a two or a twelve hour shift. A typing error meant that on one day one member of staff's hours were recorded as '07-Feb'; this had not been noticed. Numerous crossings out and alterations to the rota on one particular week meant it was even more difficult to work out whether there had been sufficient staff on duty each day. Staff rotas were not accurately maintained to show which staff had been or were due to be on duty, which meant that it was not possible to see from the records whether there were sufficient staff. This meant that the provider was in breach of the relevant regulation (regulation 20) and the action we have asked the provider to take can be found at the back of this report.

The operations manager showed us an audit tool that had been devised, so that the provider could audit aspects of the service to make sure a high quality service was being provided to people living at Laburnum Lodge. However, this was not a sufficiently robust audit tool for the provider to evidence that quality monitoring had taken place and that the service being delivered to people by the staff was meeting their needs. This meant that the provider was in breach of the relevant regulation (regulation 10) and the action we have asked the provider to take can be found at the back of this report.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**2 April 2014** **Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.** Audits and quality assurance monitoring were not completed or addressed to identify, assess and manage risks relating to the health and welfare of people in the home. **3 September 2014 this remains a breach.** **Regulation 10(1)(a) Health and Social Care Act 2008** **(Regulated Activities) Regulations 2010** The registered person did not have suitable arrangements in place to regularly assess and monitor the quality of the service provided.

Regulated activity	Regulation
	2 April 2014 **Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010. Management of medicines.** People who use services and others were not protected against the risks associated with the unsafe use and management of medicines. This was because the registered person was not carrying out sufficiently detailed medicines audits, and therefore did not have an effective quality assurance system in place for medicines. The registered person did not have appropriate arrangements in place for the safe keeping of medication because medicines were not being stored at the correct temperature to remain fit for use. **3 September 2014 The provider had made improvements and was no longer in breach of this regulation.**

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
	2 April 2014 **Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. Staffing** The provider must take appropriate steps to safeguard the health, safety and welfare of people by using relevant guidance to ensure there are sufficient numbers of staff. **3 September 2014 The provider had made improvements and was no longer in breach of this regulation.**

Regulated activity	Regulation
	2 April 2014 **Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010. Supporting workers** The provider must ensure that staff have received appropriate training in medication administration to enable them to deliver care to people living in the home. **3 September 2014 The provider had made improvements and was no longer in breach of this regulation.**

Regulated activity	Regulation
	3 September 2014 **Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** The registered person did not have suitable arrangements in place to ensure that records required for the safe operation of the service were being maintained effectively.