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The Laurels

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out this unannounced inspection on 12 October 2018. We continued the inspection on 15 October 2018 which was announced. When we last inspected in November 2017 we found breaches in regulation. Risks to people in relation to infection control and the environment had not been consistently managed. Medicines had not been administered safely. Records relating to employees had not been stored securely. Quality assurance processes had not been effective in reducing risks to people. At this inspection we found improvements had been made and there were no longer breaches in regulation.

Following the last inspection, we asked the provider to complete an action plan to show what they would do, and by when, to improve the key questions of safe, effective, responsive and well led to at least good.

The Laurels is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home is registered to accommodate up to 20 people in one adapted building and provides care to older people some of whom are living with dementia. At the time of our inspection 16 people were living in the home. Accommodation is over two floors and access to the first floor is by stairs or a stair chair lift. Rooms on the first floor are not able to accommodate people who need the use of a hoist to support with moving and transferring.

People were supported by staff who understood their role in recognising and reporting signs of abuse. Risks to people had been assessed and were regularly reviewed. Staff understood the actions needed to prevent avoidable harm including prevention of avoidable infection. People had their medicines ordered, stored, administered and disposed of safely including medicines prescribed for as and when required. When people had topical creams prescribed a body map had been completed providing care staff with details of where and how often it should be applied.

Staff recruitment checks included the disclosure and barring service to help ensure they were safe to work with vulnerable adults. Staffing levels met people's assessed care needs. All staff completed an induction and had on-going training and support that enabled them to carry out their roles effectively. Opportunities for professional development had included national diplomas in health and social care.

People had their care needs and choices assessed prior to admission and these had been used to create person centred care plans that reflected people's individuality and lifestyle choices. Care plans were reviewed at least monthly and changes to people's care needs communicated to staff at a daily handover meeting. People had their eating and drinking needs met. Information was shared with the kitchen who produced well balanced meals that provided choice and catered for any special diets. People had access to healthcare whenever needed including emergency and planned appointments. Records showed us that working with other professionals such as nurses, opticians and dieticians had enabled effective, consistent

care to people. People had an opportunity to be involved in end of life planning and had their religious and cultural needs respected.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. A complaints process was in place and people felt if they raised concerns they would be listened to and actions taken.

People had access to areas in the home for private time and a lounge and dining area for socialising. Refurbishments were under way to increase the lounge area and create a more dementia friendly environment for people. People were able to independently access a secure courtyard garden.

Relationships between people and all the staff team were warm, friendly and caring. Staff had a good knowledge of people's past histories and the family and friends important to them. People had their communication needs understood which meant they were involved in decisions about their day to day lives. People had their dignity, privacy and individualism respected.

The management of the home was visible, open and transparent. Staff felt able to share ideas and felt listened to and appreciated. Teamwork and effective communication provided a positive working environment and staff had a clear understanding of their roles, responsibilities and level of decision making. Opportunities were available for people, their families and staff to be involved and engaged with service development. Feedback had been used to continually develop the service both in respect of people and the environment.

Quality assurance processes and systems had been reviewed and new audit tools implemented that were more effective at monitoring quality and regulatory standards. The staff team worked with other organisations and professionals such as 'Skills for Care' to keep up to date with best practice guidance.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were cared for by staff who had been trained to recognise abuse and understood the actions needed if abuse was suspected.

Risks to people were assessed, monitored and reviewed by staff who knew the actions they needed to take to minimise risks of avoidable harm.

Staff were recruited safely and there were enough staff to meet people's needs.

People had their medicines administered safely.

People were protected from avoidable infections.

When things went wrong such as accidents and incidents lessons had been learnt.

Is the service effective?

Good

The service was effective.

People were involved in assessments prior to admission that gathered information about their care needs, choices and recognised their individuality.

Staff received an induction and on-going training and support which enabled them to carry out their roles effectively.

People had their eating and drinking needs met.

Working relationships with other professionals enabled effective care outcomes for people.

People were supported to access healthcare both for planned and emergency health needs.

Ongoing refurbishment was providing more communal space and an environment more suitable for people with physical and

cognitive care needs.

People were supported within the principles of the Mental Capacity Act

Is the service caring?

Good

The service was caring.

People had positive, friendly relationships with the staff team who demonstrated kindness and emotional support.

People were involved in decisions about their day to day lives.

People had their privacy, dignity and independence respected.

Is the service responsive?

Good

The service was responsive.

People had care plans that reflected their care needs and choices and that were followed by the staff team.

A complaints process was in place that was responsive and used to improve service delivery.

People had an opportunity to be involved in end of life care planning and had their wishes respected.

Is the service well-led?

Good

The service was well led.

The management team provided visible leadership promoting teamwork and an open transparent culture.

Staff understood their roles and responsibilities and felt appreciated.

Opportunities were in place for people, families and staff to be involved and engaged with developing the service.

Quality assurance processes had been reviewed and been effective in driving and sustaining improvements.

The Laurels

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out by one inspector and began on 12 October 2018 and was unannounced. The inspection continued on 15 October 2018 and was announced.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to gather their experiences of the service.

The provider had not completed a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During our inspection we spoke with three people who used the service and three relatives. We spoke with one of the owners, registered manager, four care staff, cook and the housekeeper. We reviewed six people's care files and discussed with them and care workers their accuracy. We checked three staff files, care records and medication records, management audits, staff meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

We used the Short Observational Framework for Inspection (SOFI). This is a way of observing care to help us understand the experience of people who could not talk with us.

After our inspection we spoke with a district nurse who had experience of the service.

Good

Is the service safe?

Our findings

When we last inspected the service in November 2017 we found a breach in regulation. Risks identified for people in relation to infection control and safe premises had not been consistently managed or actions taken to minimise the risks. People were at risk as medicine administration was not always carried out in a safe way. At this inspection we found that improvements had been made and the service was no longer in breach of regulation.

Staff had completed infection control and food hygiene training and we observed them following good practice guidance. A cleaning rota had been introduced and completed daily by both the housekeeping team and the night staff. The housekeeper told us, "The cleaning rota is working really well. I sign off all that I have done and the night staff sign off there's. If I'm on holiday there's back up". All areas and equipment were clean and odour free.

Environmental risks had been addressed and each room had hot running water. A refurbishment programme was under way and included the installation of a new shower room on the first floor. Appropriate signage had been placed on an upstairs fire exit. Building contractors were working in the home and the registered manager could explain how risks to people had been managed.

People had their medicines ordered, stored, administered and recorded safely. A locked fridge solely for medicines was being used to store temperature sensitive medicines and temperatures were checked daily. Some people had been prescribed controlled drugs which are medicines that require additional storage and administration safeguards than other medicines. These were being stored and administered in line with legislation.

When medicines had been prescribed for 'as and when required' (PRN) protocols were in place. These provided details of what the PRN medicine had been prescribed for and how it should be administered. Some PRN medicine had been prescribed for pain management. When people were unable to verbalise that they were experiencing pain an assessment tool had been used. This described the signs a person might be showing such as becoming agitated, grimacing or frequently touching a part of their body.

When topical creams had been prescribed for people's skin conditions a body map showed staff where it needed to be applied and detailed how often. We checked medicine administration records and people had received their creams as prescribed.

People and their families told us they felt the care was safe. One relative told us, "(Relative) is always happy, clean and I don't have any issues with the staff". All staff had completed safeguarding training and understood their role in reporting any concerns including reporting poor practice. The registered manager understood their responsibility ensuring concerns would be raised appropriately with external agencies such as the local authority and CQC. People were protected from discrimination as staff had completed training in equality and diversity and recognised and respected people's individuality.

Assessments had been completed that identified risks people experienced. Staff understood the actions needed to minimise the risk of avoidable harm and were vigilant at reporting changes to senior staff. Risks were reviewed at least monthly and people and their families had been involved in decisions about how risks were managed. One person had lost weight and records showed us that a high calorie supplement had been introduced and their weight stabilised. Another person had a risk of falls and an alert alarm mat had been placed at the side of their bed to alert night staff when they were up and needed supervision. One person had a risk of skin damage and had a specialist air mattress on their bed. Records showed us they were assisted regularly with changing position in bed and that the accuracy of the air mattress was checked daily.

People had personal emergency evacuation plans (PEEP) which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency such as fire or flooding.

Staff had been recruited safely including checks with the disclosure and barring service to help ensure they were suitable to work with vulnerable adults. People told us there were enough staff to meet their needs. One person told us, "I have a bell for if I need help in the night. They come quickly if you ring the bell; they come and help you". We observed the management team providing care to people and working alongside care workers covering staff absence.

Good

Is the service effective?

Our findings

People were supported by staff that had completed an induction and on-going training that enabled them to carry out their roles effectively. A training matrix had been kept up to date which demonstrated the training all staff had completed and, where necessary, the date for refresher training. A care worker explained how dementia training had impacted their practice, "It showed me the different behaviours and helped in how to deal with certain residents. One resident can get scared and worried and if I sing with them it calms them down; we sing together".

Staff received regular supervision and told us they felt supported in their roles. Opportunities for professional development had included national diplomas in health and social care.

Changes to the communal areas were on-going and included an extension underway to the lounge area. People and the staff team had been involved in planning the space and decided on skylights to increase the natural light. Ramps into the lounge were being levelled off to provide easier mobility for people. Bathroom areas had been refurbished and included raised toilets to aid people's independence. In some areas carpet had been replaced with a non-slip wood appearance material to reduce slip and trip risks and aid cleaning. One person had chosen blue for their bedroom and decided on a blue bedroom door as well. An external door knocker had been added which staff used before entering the room. Outdoor secure space was available in a courtyard and accessible independently from the lounge area.

Signage to help people stay orientated to place and promote independence remained limited. The registered manager told us they would organise for a board and a clock in the lounge that detailed the day and what was happening. Pictorial signage had been used to help people orientate themselves to the toilets.

People and their families had been involved in a pre-admission assessment which had been used to gather information about their care needs and lifestyle choices. The assessment gathered information about a person's medical history and how they needed support whilst reflecting their level of independence. The information had been used to create person centred care plans which had been developed in line with current legislative standards and good practice guidance. Where assessments had identified a need for equipment such as a pressure relieving mattress these had been put in place prior to admission ensuring effective care. One person had been in hospital and the registered manager had arranged to visit them to reassess their care needs prior to discharge. They explained this was to ensure any changes could be planned for prior to returning to The Laurels.

People had their eating and drinking needs understood by both catering and care staff. We observed people being offered choices at mealtimes. One person told us, "I must admit it's good food. You get a choice, today was casserole or meat pie. This apple pie is delicious". We observed people being served well balanced nutritional meals. Information about people's likes dislikes, and any special dietary requirements, had been shared with the catering staff. We saw that people had access to drinks throughout the day. Adapted crockery had been provided such as plate guards and beakers with two handles to support

people's independence. When people needed the assistance of staff with eating and drinking, this was carried out sensitively at the person's own pace ensuring their dignity.
The service worked with other organisation to ensure people had effective care. This included community district nurses when people needed support with diabetes or wounds and community mental health teams when people needed support with their dementia. Each person had a 'grab sheet' which provided essential care information which would accompany them if they needed to move to another service such as a hospital admission.

People had been supported to access healthcare both in planned and emergency situations. We observed one person telling staff they were experiencing tooth pain and an emergency appointment had been organised for later that day at a local dentist. A relative told us, "They will take (relative) to hospital appointments and will call a doctor if needed. Never any delay, never waiting for it to be convenient".

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 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 working within the principles of the MCA. Mental capacity assessments had been completed for people and DoLs applications had been submitted to the local authority. When people had been assessed as not having capacity decisions had been made in the person's best interests and included families and health professionals. One example had been a person who had been assessed as not understanding the risks associated with declining some essential medicines. The best interest decision had included discussions with their GP and had concluded medicines needed to be given covertly.

We observed staff seeking consent from people and offering choices before providing any interventions. This included joining in activities, going out for a walk and where to spend their time. When people declined an intervention we saw this was respected. Care records showed consent had been obtained appropriately for photographs, use of bed rails and reading mail. Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a persons' behalf. This meant people were having their rights upheld.

Good

Is the service caring?

Our findings

People and their families described the staff as kind and caring. One person told us, "They are kind (staff). They don't do anything nasty". A relative said, "Definitely caring. They care for (relative) as much as I would if I was caring for (relative)". Another told us, "100% all the way. Very attentive, caring, keep you posted". We spoke with a district nurse who told us, "The heart of it all are the people living there. They (staff) are really caring". We observed relaxed and friendly relationships between people and all the staff team. We observed one person standing and smiling with the cook in the kitchen. The cook told us, "(Name) loves coming in the kitchen for a cup of tea and biscuit".

Staff spoke compassionately about one person's recent bereavement and described the additional emotional support they had been able to provide. We read how care staff had been encouraged to spend more time with the person, sitting with them, encouraging them to talk with simple, gentle questioning.

Staff demonstrated a good understanding of people's past lives and family and friends important to them. A relative told us, "Always (staff) very welcoming, offering cups of tea and lunch". We observed conversations taking place between people and the staff team about local places they had visited, family events and topics in the daily newspaper. This meant people could have conversations that were meaningful to them. Bedrooms were personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home.

People had their communication needs understood and met. One person was unable to talk but staff told us, "But they smile and giggle and reach out with their hand if they want your time". Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. For example, talking with people at eye level and using hand gestures and facial expressions. People who needed an independent representative to speak on their behalf had access to an advocacy service.

People and their families felt involved in decisions about their care and day to day lives. One person told us, "I tell staff things like 'I don't want those shoes on today'. If you ask them to do something for you they always do". We spoke with one person who was snuggled under their duvet who told us, "I'm having a lie in today". A relative told us, "They keep me involved. I can go anytime and look at the book, (care and support plan), and see what (relative) has been up to".

People had their dignity, privacy and independence respected. When people wanted time in their rooms alone we saw this was respected. We observed staff knocking on doors waiting to be invited in. We observed staff quickly providing a person with a shawl when their clothing accidently compromised their dignity. People's clothes and personal space were clean and reflected their individuality. We observed people being supported with their independence; being supported to carry out tasks at their pace such as walking with an aid.

Information about people and staff was stored securely to ensure their right to confidentiality.

Good

Is the service responsive?

Our findings

People had care plans which reflected their personal care needs and choices and were reviewed at least monthly. Care staff were able to demonstrate a good knowledge of the actions needed to meet people's care needs and choices. We read a speech and language therapist report that had praised the actions of staff; 'Staff every day help (name) with speech exercises'.

Health fact sheets about people's medical conditions provided clear details of how this impacted on a person and provided care staff with information to help recognise changes. An example was a fact sheet on diabetes describing how high or low sugar could affect the person's mood and energy levels and what to do if they appeared unconscious.

Staff described communication as good and felt they were kept up to date as changes with people were discussed at a daily handover. A care worker told us "I had a couple of weeks off and been handed over everything I missed out on such as (name) in hospital".

The service met the requirements of the Accessible Information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. Some people had consented to have their mail read to them which meant staff could ensure their understanding of any information. One person had poor verbal skills and had preferred to write down messages.

People had opportunities to join in group activities, spend one to one time with staff and access the local community. An activity plan was displayed on the wall and included musical entertainers, exercise to music classes, arts and crafts and games. Some people had photograph albums that families had helped put together. A care worker told us how it provided a great source of pleasure to one person who enjoyed seeing photographs of a family pet. One person told us the care staff painted their nails and proudly said, "I love this shade of pink". A relative told us, "(Name) loves to help. (Registered manager) has (name) in the office sort of keeping her busy". We observed people reading a daily newspaper of their choice. On the first day of our inspection people sat together watching a royal wedding on the TV.

Trips into the community had included a visit to a local pub for lunch, coffee shops, garden centres and the local quay. The registered manager told us how they had taken one person to the town they had previously lived in and they had enjoyed a reminisce and drink together in their old local pub.

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government and social care ombudsman. No complaints had been received since our previous inspection. A relative told us, "I can talk to (registered manager) any time. We exchange views and ideas. Very satisfied with how they handle things".

People had an opportunity to develop care and support plans detailing their end of life wishes which

included any cultural requirements and decisions on whether they would, or would not, want resuscitation to be attempted.

Good

Is the service well-led?

Our findings

When we last inspected the service in November 2017 we found a breach in regulation. Systems and processes were not effectively assessing, monitoring and reducing risks to people related to their health and welfare. Records were not stored securely for staff employed to carry out a regulated activity. At this inspection we found that improvements had been made and the service was no longer in breach of regulation.

The registered manager had introduced systems and processes to ensure that risks to people were minimised. This included actions in relation to managing preventable infections such as cleaning schedules, staff training and a robust auditing process. Information about employees had been stored securely.

People, their families and the staff team all described the management of the home as open and transparent. One person told us, "(Registered manager) does a lot. She comes and speaks with me; we have a good talk". A care worker told us, "I feel comfortable around (registered manager) and would be able to share any concerns".

Staff told us they felt appreciated in their roles and that the management were supportive and flexible in supporting their work and personal life commitments. A care worker told us, "We had a gift of perfume to thank us for our work". Another told us, "I feel appreciated, I'm told verbally or they drop me a text. Even the odd hug".

Staff were clear about their roles and responsibilities and were focused on the importance of teamwork. Management was visible, and both the registered manager and owner worked alongside the care team providing support to people. A care worker said, "We are such a close family of workers".

The registered manager had a good understanding of their responsibilities for sharing information with CQC and other statutory organisations and our records told us this was done in a timely manner.

People, their families, and staff had opportunities to be engaged and involved in developing the service. A relative told us, "If I'm going to visit at a weekend (registered manager) will say just text and I will pop and see you". Staff meeting minutes noted that information had been shared about people, new legislation and plans for the environment.

Auditing and monitoring tools had been reviewed and were more effective in identifying areas of improvement such as medicine management and infection control. When improvements had been identified actions had been taken promptly. We looked at an environmental health and safety audit which highlighted a window would not open and saw that a glazier had been contacted to repair it.

In response from feedback from people and their families additional staffing hours had been introduced so that people had more opportunity to access the community. Staff feedback had led to a review of continence materials and a new process had been introduced that was more person centred and

accessible.

The staff team worked with other organisations and professionals to ensure people received good care. These included 'Skills for Care' to keep up to date with best practice guidance.