Methodist Homes

Laurel Court (Didsbury)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 2 and 7 June 2016. We last inspected Laurel Court in September 2015 at which time the home was found to be non compliant in relation to Staffing and Safe Care and Treatment. The breach of Safe Care and Treatment was with regards to the safe administration of medication.

Laurel Court is in Didsbury, Manchester and is owned by Methodist Homes. It provides residential and nursing care as well as care for people living with Dementia. The home provides single occupancy rooms with en suite facilities and is registered with the Care Quality Commission (CQC)
to provide care for up to 91 people.

There are four units at the home, known internally as Wilmslow (privately funded dementia), Burton (dementia), Palatine (residential) and Broadway (general nursing). At the time of the inspection there were 78 people living at the home, across the four units.

At the time of our inspection, the home manager was not yet registered with CQC and was going through the application process. The manager had worked at the home since April 2016. 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 living at Laurel Court told us they felt safe. Staff we spoke with were aware of safeguarding procedures and had received training in safeguarding of vulnerable adults. We looked at recruitment records and saw that all the appropriate checks had been carried out to help ensure staff were of suitable character to work with vulnerable people. This included undertaking DBS checks and seeking two or three written references from previous employers or people of good character. The manager outlined the additional staff recruited to the service since the last inspection and the recruitment programme was on going at the time of this inspection

At the last inspection staff told us they did not think there were sufficient numbers of staff on shift to meet people's needs in a timely way. Whilst some staff told us this was still the case this was not what we observed over the two days of inspection. We saw no one waiting for support, nor calling out for long periods of time. Call bells, when sounded, were answered in a timely way and the atmosphere on all units was calm and unhurried.

We looked at how the home ensured people received their medication safely. We saw improvements had been made since the last inspection . There were two nurses on the nursing unit dispensing medication and people received morning medicines in a timely way.

The service carried out risk assessments in relation to people's health and care needs and measures were identified to minimise risks wherever possible. There was an viral outbreak on one of the units on the first day of inspection. Whilst the home had taken appropriate measures to contain the infection and minimise the risk of it spreading we saw that not all staff practised good infection control measures. There was also inappropriate storage of new continence products.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We checked whether the service was working within the principles of the MCA. We found the service had completed mental capacity assessments and made best interest decisions for people when appropriate however, capacity assessments had not been decision specific. Staff had a general understanding about the MCA and DoLS, but were not completing assessments correctly. We saw the service had made referrals for people to be assessed for a DoLS appropriately.

Two of the units at the home (Wilmslow and Burton) catered for people living with dementia and we checked to see what improvements had occurred to make these units more 'dementia friendly' for people. People had specific 'memory boxes' outside their bedrooms to remind them of past life events. These contained photographs and personal items important to the individual. There were distraction activities on corridors and items of interest, for example a selection of hats. Corridors also contained appropriate colourful wall stickers and large, framed pictures of local areas in times gone by. Signage around these units had improved and meant that people were signposted to communal areas such as the lounge, dining room and bathroom/toilet areas.

People told us they had enough to eat and drink, although some people did not always like the food on offer. We saw information was available to help ensure any special dietary requirements were catered for. There was evidence in people's care plans that referrals were made and advice sought from other health professionals as required. Communication between care staff and catering staff was good in relation to people's diets and specific food requests, however menu choice forms were in different formats for each unit and were therefore inconsistent.

We observed staff interacting with people in a positive, respectful and friendly manner. People told us staff were kind and caring. Staff were able to describe how they would support people to retain their independence and we observed aspects of this during the first day of inspection, particularly during the lunch time meal.

The service sought feedback from people using the service through surveys and resident and relatives meetings. We saw minutes from meetings and comments from people in relation to the meal time experience survey. Care plans demonstrated that people's views had been considered and recorded.

We saw a range of activities being undertaken on the day of the inspection. An external company visited three units and did a variety of chair exercises, tailored to people's capabilities. We saw photographs displayed around the home of outings and entertainment that had happened in the home. People's spiritual needs were met by the presence of a chaplain, a regular visitor to the home. Services were held in the home and the chaplain was making links with other religious denominations.

People, staff and relatives told us they felt comfortable approaching the new manager with any concerns and were confident that these would be addressed.

A range of audits and checks were undertaken by the manager to monitor the quality and safety of the service. Head of Department meetings took place on a weekly basis and included the manager, the deputy manager, the chef, the housekeeper, heads of units and a maintenance representative. Staff meetings were in place and occurred on a monthly basis. Topics for discussion in these meetings included moving and handling, infection control, laundry and administering medicines.

The overall rating for this service is 'requires improvement'. During this inspection we found one breach of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

People told us they felt safe and family members stated they had no concerns about their safety.

Staffing levels had improved and recruitment was on going. Some people told us there were sometimes delays in morning routines. We saw no evidence of staff not responding to meet people's needs in a timely manner.

Measures were in place to prevent the spread of infection but these were not always adhered to by staff.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to receive nutrition and hydration however feedback about the food on offer was mixed.

The service was meeting the legal requirements relating to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) although some staff's knowledge of the legislation was basic.

Improvements had been made to the environment. Healthcare professionals we spoke with were complimentary of nurses, staff and managers of the service.

Is the service caring?

Good

The service was caring.

We observed positive caring interactions between staff members and people living at Laurel Court. Care workers were patient and kind.

People who lived at the home said that staff treated them with dignity and respect. Staff were able to provide us with examples of how they maintained people's dignity when providing personal care.

Care plans contained a final wishes record. This allowed the person the chance to express what they wanted to happen in their final days.

Is the service responsive?

Good

The service was responsive

Care plans were detailed and informative. They included information about the person and their likes and dislikes. People were involved in making decisions about their care.

People's spiritual needs were met by the presence of a chaplain on site. The current chaplain was making links with other religious denominations.

Complaints were handled within company policy timescales and the outcomes of complaints was documented.

Is the service well-led?

Requires Improvement

The service was not always well managed.

At the time of our inspection the home manager was not yet registered with CQC and was going through the application process. They had been in post since April 2016.

Staff told us that managers were approachable and they felt supported. Staff meetings took place on a monthly basis.

There were audits in place to monitor aspects of care and the manager had oversight of the quality of the service, assisted by the management system "You Comply."

Laurel Court (Didsbury)

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 2 and 7 June 2016. The first day of inspection was unannounced. The inspection team consisted of two inspectors 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 service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

As part of the inspection we reviewed the information we held about the service. This included contacting the care commissioners in Manchester and healthcare professionals who were involved with people using the service.

We spoke with eight people using the service and 12 staff employed by the service, including the acting registered manager, the area manager, three nurses, five care staff, the activities co ordinator and a domestic. We also spoke with three health professionals visiting the home on the day of inspection and six relatives.

We looked at 8 care plans (three on Burton unit, three on Palatine unit and two on Broadway unit). We also looked at ten medication administration records and the controlled drugs record book. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of the people who could not talk to us.

We observed the way people were supported in communal areas and looked at records relating to the

service. These included three staff recruitment files, daily record notes, medication administration records (MAR), maintenance records, audits on health and safety, accidents and incidents, policies and procedures and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe. One person said, "I feel safe and secure and I'm not frightened here." Another person also told us, "Yes I do [feel safe]. They check on you throughout the night." A relative we spoke with said, "Yes my mother is safe here and I am happy with the staff." Nobody we spoke with indicated that they fet unsafe or that staff made them feel unsafe.

At our previous inspection in September 2015 we identified that there were insufficient staffing levels to look after people safely. The new home manager had been in post since April 2016 and was awaiting registration with the Care Quality Commission. They told us about the improvements the company had made with regards to the recruitment of staff and increase in staffing levels.

The units in the home had recently been reconfigured and people with nursing needs lived on Broadway unit, on the top floor. The third floor, (Palatine unit) was now for those people who were more independent and had lower level needs, so consequently only 14 people were living on the unit on the days of our inspection. We saw that staffing levels were flexed based on the number of people living on units and the level of support required. Rotas confirmed this and reflected that cover was obtained for staff sickness and annual leave.

We spoke to a number of people and staff about staffing levels and received different responses. One person told us staff were 'always in a rush' and that sometimes breakfast was delayed for them. One member of staff on Broadway unit told us, "I think there are enough staff; no problem at all," whilst another on the same unit commented, "Mostly [there are enough staff] but there are too many agency staff and not enough regular staff." Other staff acknowledged the improvements made to staffing levels and told us, "Yes they are getting better," and "Definitely getting better."

We spoke to the manager about the use of agency staff who explained that long-standing staff had left for alternative employment or had retired, which had created vacancies within the home. The recruitment of staff was a high priority for the home and the company had recently increased the rate of pay for all care staff. This had been done with the full consultation of all company staff and reflected an hourly rate in excess of the living wage. The home hoped to attract a number of high calibre applicants in offering the increased hourly rate.

Whilst the recruitment drive was continuing the service was using agency staff, but this was as a last resort. Formal mechanisms were in place for staff already employed at the home to indicate if and when they were able to cover particular shifts, for absent colleagues or vacant posts. The home then approached staff from the wider company, based in other homes. Any shifts still not covered were then offered to agency staff. We saw that the home used a local recruitment agency and were using the same agency workers, when this was possible. This meant that after an initial shift some agency workers were familiar with people living in the home and could support them accordingly.

We saw sufficient staff on duty on each unit at Laurel Court on the days of our inspection. Staff on Burton

unit felt there were sufficient staff to meet the current needs of people living on that floor. One staff member said, "Staffing levels are ok at the moment; it's better when there are two seniors on in the morning to do the medicines round, otherwise it takes a long time". We observed the care and support provided on this floor and saw that people's needs were met in a timely manner and no one had to wait to have their needs met. However we were told by relatives that this wasn't always the case and there were "not enough staff" on some occasions.
A monitoring visit on the service had been carried out by the local council in March 2016. The officer had looked at staffing levels as part of the monitoring visit and their report included the comment, "The staff did not appear to be rushed when attending to customer's needs."

We saw no evidence that people were not attended to within acceptable timescales. The atmosphere on all floors during the two day inspection was calm and pleasant. We heard no one calling or shouting for help .Call bells, when rang, were attended to promptly and staff did not appear hurried or under pressure when undertaking their duties. We were confident that management were addressing the problem of recruitment and keeping people safe whilst doing so.

We looked at five recruitment files and found the provider followed a robust recruitment and selection process to ensure staff recruited had the right skills and experience to meet the needs of people who lived in the home. Personnel files were in good order. The correct paperwork was on file in relation to the recruitment process and recruitment records for staff included proof of identity, two references and an application form. Disclosure and Barring Service (DBS) checks were in place for those employed by the service. DBS checks help employers make safer recruitment decisions to minimise the risk of unsuitable people from working with people who use care and support services. This meant that people who used the service could be confident that staff appointed were suitable to work with vulnerable people.

As part of the inspection we checked to ensure that medicines were administered, stored and disposed of appropriately. We observed people receiving their medicines. We saw that staff locked medicines trollies each time these were left unattended. We saw one staff member make contact with a person and get down to their level to engage with them. The staff member then explained they had their medicine and would they take it for them. We heard the staff member say to one person, "[name of person] are you ok to take your medication for me?" and, "Are you in any pain; do you need painkillers?" The staff member gave the person time to take their medicine, ensuring they had sufficient water to take the medicines with.

We checked the medication administration records (MAR) and saw that there were no gaps, and it was clearly recorded when people had refused to take their medicines or had not required it. Staff explained that when someone refused to take their medicine, they would try again later. If they still refused then this was recorded and medicines were disposed of in a safe manner. If this refusal continued staff told us they would inform the GP and senior managers.

We saw the service had a safe process by which they disposed of unused medicines. We also checked that the controlled drugs were being stored and administered correctly. We saw they were stored securely and that everything had been signed by two staff members before they were administered. This meant that controlled drugs were being administered safely. We saw that fridge temperature checks were recorded daily to ensure those medicines which required to be stored in the fridge, were done so safely. We saw that when people were prescribed 'as and when' medicine (PRN), there were appropriate protocols in place to support staff to know when to administer these.

The deputy manager was responsible for completing medication competency assessments on all staff trained to administer medicines. These assessments were detailed and involved questions, observations of

practice and discussions with the staff member before competency was approved.

We looked at peoples care files which showed detailed risk assessments which were personalised to each persons needs. For example, there was a risk assment for bed rails as the person was at risk from falling out of bed. However, this person had capacity and did not want them to be fitted. Instead the service had recorded this and had asked if the person would have a sensor mat instead which would alarm should the person fall. We saw that the risks had been discussed with the person and they had agreed to the sensor mat. This showed that that the service had identified the risk and taken action to minimise this, whilst taking into account the individual's personal preferences.

We saw where safeguarding incidents had occurred, sufficient actions had been taken and protection plans put in place to prevent it from occurring again. The home also had mechanisms in place to safeguard people from financial abuse. All income and expenditure for people living in the home was receipted and individual spreadsheets documented this. A monthly safe check was undertaken by relevant staff, when all balances were checked, and a head office audit was performed every six months to verify this.

The home employed two bespoke maintenance staff and we saw that regular checks on the building and equipment were undertaken and documented accordingly. The majority of these checks were done on a weekly or monthly basis. Some examples of these checks included pull cords; fire panel and emergency lighting; wheelchairs; profile beds; window restrictors and thermostatic valves.

At the time of our inspection there was an outbreak of a sickness bug that initially affected Wilmslow unit and then Burton unit. On the first day of inspection we saw that the home had taken the correct precautions in isolating the affected Wilmslow unit and had informed people, relatives, visitors and staff about the outbreak. On the second day of inspection we were able to visit Wilmslow unit and saw documented evidence of actions taken during the outbreak. Once no new cases had been identified for 48 hours a deep clean had been carried out to the unit on 6th June, in line with infection control procedures.

The home environment was clean and with no odours. One person we spoke with told us, "The home is clean; I am happy with that." Another relative however, told us that they had resorted to leaving notes for staff to ensure that a person's en suite toilet was cleaned properly. "When you ask it gets done eventually," they said. Staff had completed infection control training and told us there was always access to personal protective equipment, such as gloves and aprons.

When looking round the home we found the sluice area door on the top floor had been left unlocked. There were yellow bags in the sluice room that denoted clinical waste contents and we saw that one of these was open, with some spillage of used tissues on the floor. A bathroom opposite the sluice area was also being used to store clean, unused continence products and we noted that these were on the floor. Both these practices do not promote good infection control and staff should ensure that all waste is disposed of properly and unused products are stored appropriately, to prevent the likelihood of any cross-infection occurring.

This was a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

We looked at how staff were supported to develop their knowledge and skills, particularly in relation to the specific needs of people living at Laurel Court. One member of staff we spoke with told us they had received no induction prior to starting working however, newer staff we spoke with told us they had. One new employee explained they had recently completed a one week induction programme prior to starting to work on the units, followed by a period of shadowing senior members of staff. Another staff member confirmed they had undertaken e learning training in safeguarding and infection control during their induction. We were confident that staff were receiving a thorough induction and this meant they understood their roles and responsibilities within the home and as part of the wider team.

We examined the training records and spoke with staff who spoke highly of the training on offer. Those we spoke with told us training was provided on a regular basis. Two members of staff told us they felt confident in their roles because of the training on offer. Training records showed that staff were offered on-going training opportunities and refresher training in areas such as moving and handling, safeguarding, medication, fire safety, dementia, infection control, Mental Capacity Act 2005 and deprivation of liberty safeguards.

The senior carer on Wilmslow unit was one of two staff nominated to attend a train the trainer dementia programme hosted by Stirling University. The manager told us that once trained both staff would cascade knowledge to all staff at Laurel Court, prioritising those working with people with dementia.

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.

We saw staff asking for people's consent, prior to them carrying out any care and support. One staff member was heard saying, "Good morning [name of person], would you like to get up now?" the person replied and the staff members said, "I'll be back in a few minutes then [name of person]". All staff were seen knocking on people's doors before entering people's bedrooms.

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 Mental Capacity Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found the service had completed mental capacity assessments and made best interest decisions for people when appropriate. Where staff had completed mental capacity assessments however, they had not asked the person to recall what was being discussed about the specific decision they wanted to make. Instead staff had asked them to recall five inanimate objects. For example, one person needed to be assessed to make a decision about

remaining in 24 hour care. Staff had asked them to remember and name five objects, rather than go back and ask them to recall what decision they were trying to make. This showed that staff had a general understanding about the MCA and DoLS, but were not completing assessments appropriately. We saw the service had made referrals for people to be assessed for a DoLS appropriately.

We spent time on three units on the first day of inspection. Two of the units we visited had different menus reflected on the boards in the dining area. There was a weekly menu board on the wall in the dining room of the Burton unit, however this had not been updated.

We observed a lunch time meal on two units and saw that nearly all the residents ate in the dining room. One person was supported to eat their meals, whilst others were encouraged to remain as independant as possible and given the option of 'finger foods' so they were able to feed themselves. We observed staff asking if they wanted support to cut up their food and were shown visual choices of the different meals on offer.

There was confusion amongst the staff we spoke to as to what meal was to be served at lunch time on the first day of inspection. This meant that people living at the home were misinformed about what food was on offer at lunchtime. The spinach soup we saw served during the lunch time meal was declined by some people who had previously chosen it and we saw that these people were offered alternative food choices.

One person received a pureed diet at lunch time. We saw that the separate pureed food items were served individually on the plate which made the meal look more appealing. Feed back with regards to the food on offer was mixed. One person told us, "The food is lovely." Another comment we saw on a meal experience feedback form was about the Sunday lunch. "I really enjoy the Sunday lunch. It is amazing." Other people living at Laurel court were not as complimentary about the food on offer. One person told us, "The food is not good." Another told us, "There is plenty of food but no one wants it." A relative we spoke with said, "My [relative] doesn't like the food so we bring in a lot of food."

At the time of our inspection the service was looking to recruit a catering manager. We spoke with the chef who displayed relevant knowledge with regards to the varied diets that people received. We saw that the kitchen received communication and documentation from senior staff when new people were admitted to the home with regards to the appropriate diet they needed to receive. One resident had recently had an assessment from the Speech and Language team (SALT) due to swallowing concerns. The kitchen had received paperwork that the person's diet needed to be altered to pureed foods, as this was the outcome of the SALT assessment. This meant that people living at the home received food served for them in the correct format, which kept them safe and reduced the risk of choking.

We saw that the format of the document used to indicate people's meal choices was different on all three units. Burton unit's menu choice form did not have the option to indicate that a pureed diet was a requirement. We were aware that at least one person on the unit required a pureed diet. We saw that staff were ticking the 'soft' diet column and handwriting soft. Whilst the cook was fully aware of people's correct dietary requirements there may be an occasion when this is not the case. It is imperative that catering staff are supplied with the correct information so that people receive meals and drinks in the right format and consistency to avoid any potential choking risks.

Whilst we were talking to the chef in the kitchen, staff on different floors rang down food requests, based on people's preferences. One person wanted brown bread and orange juice, another request was for 'a tea cake on the third floor'. Both requests were responded to within minutes and showed that people had access to food snacks outside of main meal times.

Two of the units at the home (Wilmslow and Burton) catered specifically for people living with dementia. On the first day of inspection we were not able to visit Wilmslow unit due to an outbreak of a sickness bug however this had cleared by the second day of our inspection. We were able to check both units to see if the environments had been designed to promote people's well being, ensure their safety and to see what measures had been put into place to make the environments more 'dementia friendly' for people.

We saw that improvements had been made since our last inspection. There was signage to the dining areas and on toilet and bathroom doors to assist people with dementia to orientate around the home. Corridors on the units contained activities for people with dementia.

On the Wilmslow unit we saw a variety of hats hanging on wall pegs and various coloured handkerchiefs. The senior carer told us that these were well used by people walking down the corridor and stimulated conversations for people. We saw interactive puzzles on the wall, containing locks and chains, good for keeping a person with dementia engaged and interested. Memory boxes were outside bedrooms and contained photographs of the person, chosen by themselves or other family members. Walls were decorated with colourful transfers and there were framed pictures of old, local scenes. Again these assisted with engaging people in conversation as many people living on the unit were local and identified with the places in the pictures a member of staff told us.

We saw that rooms were personalised with family photographs and ornaments. People living on the Wilmslow unit also had direct access to a secure garden area and were always supervised when using this space. The senior carer we spoke with on the unit had other suggestions to improve the unit, one being differently coloured bedroom doors, to further assist people with dementia to orientate around the home.

Care files showed people were supported to maintain good health and referrals were made to healthcare services as required. We saw where one person was struggling to swallow a normal diet, a referral had been to the speech and language therapist (SALT). The care records showed the SALT had visited and recommended the person have normal fluids but a soft diet.

We saw that a care plan and risk assessment had been added to this person's care file so that staff were aware of the changes in their diet. We also saw this documented in the satellite kitchen on the unit where they lived so all staff could see when serving meals. We also saw when someone began to get unexplained bruising, the service had contacted the GP. The GP had visited and confirmed the bruising had been caused by the persons new medicine. The service had implemented a clinical risk assessment in response to this.

During the inspection we spoke with three healthcare professionals visiting the home. We received positive comments from all, who referred to management as being 'very quick off the mark' with referrals into their particular healthcare services. They told us that care staff were 'always extremely helpful' and one professional added, "[The] nursing staff are very, very good." This showed us that timely referrals were made to appropriate professionals and that people living at Laurel Court received additional health care services as and when they needed it.

Good

Is the service caring?

Our findings

We saw that interactions between staff and people living at Laurel Court, were kind and caring. Staff knew people they were caring for and gave us examples of people's specific needs or preferences.

Everyone we spoke with said the staff were caring and kind. One person said, "The staff are very kind and helpful." Another person said, "They are very kind. They apologise if it's [personal care] uncomfortable to me." Relatives told us, "Staff are lovely."

We observed positive caring interactions between staff members and people living at Laurel Court and their relatives. We saw staff laughing and joining in banter with some people and taking a more formal approach with others. This showed staff knew people well and how they preferred to be addressed. Staff were seen responding to people's needs quickly and in a caring way. When communicating with people, staff would get down to the person's level and address them by their name (or preferred name) and spoke clearly. One member of staff asked a person as they sat at the table in the morning, "Would you like your tablets now or with your breakfast?" They waited for a reply before they took any action. This meant that staff were providing people with choices with regards to how and when they received aspects of personal care.

We looked at people's care files. These showed that where possible people's views had been considered and recorded for example, we saw that people were able to say at what time they preferred to go to bed and how often they wanted to be checked on. We saw that when a person was unable to contribute to their care plans, staff had sought information from the persons relatives.

We saw that all care files contained a final wishes record. This allowed the person chance to express what they wanted to happen in their final days. We saw some people wished to remain at Laurel Court rather than be admitted into hospital. Some also wanted the chaplain to attend to speak with them. It was clear who they wanted to be contacted and what was important to them at this time. We saw where people had refused to discuss this, staff would record this and review each month. This showed the service recognised the importance of end of life care and making plans in advance so that people could be supported to choose where they died and what they wanted to happen after.

We saw people's privacy and dignity was respected at all times. People's bedrooms doors were kept shut at all times and staff knocked before entering. We saw where one person had left their room in just their bed wear, staff immediately intervened and suggested they returned to their room so they could get dressed for breakfast. Another person had spilt some soup on their shirt; staff saw this and asked if they wanted to go and change it. This showed staff were maintaining people's dignity in a respectful way.

Staff asked people prior to serving the lunch time meal if they would prefer to wear an apron to protect their clothing from spillages. We saw that several people chose to wear one and were provided with laundered clothes protectors that fastened at the neck.

We observed the majority of staff being kind and caring during the lunch time meal. Milk was accidentally

spilled by a person. A care worker wiped this up discreetly and asked if the person wanted more milk. Another staff member placed a meal in front of a person and asked if they would like it chopping into more manageable pieces. This meant that the person was able to eat independently. People who declined the soup choice were offered alternatives. A care worker said, "I've got sandwiches or sausage and chips. Which would you like?" The care worker also outlined what fillings were available in the sandwiches being served, displaying patience whilst the person made a decision. The person chose sausage and chips and then said, "Aren't you kind."

Not all staff however, displayed the same attitudes. On the nursing unit four people were assisted to eat the lunch time meal. We observed that some staff undertaking this task did not communicate with the person. There was very little interaction and therefore, people were not kept informed of what food they were eating or what the care worker intended doing next. We noted that meals were served to people at the table with cling film still attached to the underside of the plates in some cases. This is not indicative of good, person-centred care. We brought these points to the manager's attention who told us staff would be reminded of good practice.

Good

Is the service responsive?

Our findings

People received individualised care which met their needs. Their care plans were detailed and informative. They included information about the person and their likes and dislikes. People and their relatives, where appropriate, had been involved in writing the individualised plans. By involving people and their relatives, the service was able to build a picture about the person, their needs and how they would want to be supported. The care plans were updated regularly to ensure that the information was accurate and a true reflection of the person's current needs. They provided clear guidance to staff about the person, and provided them with clear instructions on how to manage specific situations.

We saw people's care files recorded how they received personalised care which was responsive to their needs. Each care file contained a 'Life Story' which recorded what was important to them. We saw care plans had been personalised to each person. For example, one person their support plan in relation to personal care, showed they preferred female carers to support them. It went on to say this person was determined to do as much as possible for themselves and for staff to encourage this and support when necessary. We also saw this person had a falls risk assessment which showed that the person was on medicines which could contribute to them falling. Staff had identified this and put plans in places to minimise this risk. This showed the service was responsive to each persons needs and ensured that appropriate care and support was being provided to each person.

Care files also recorded people's preference in relation to what time they wanted to get up and dressed and what time they liked to go to bed. Care files showed that people who required regular checks and turns were receiving these as documented and staff were recording when they had undertaken the task. We saw when someone began to lose weight, the service had put in a short term care plan to support this. This showed the service was responsive to the person's changing needs. Where people had wounds or pressure damag there was clear guidance for staff to follow with detailed care plans to manage the wound.

One person had a support plan to manage their epilepsy, we saw this was reviewed regularly and the GP had been consulted when necessary. There was a clear action plan for staff to follow if the person had a seizure and when it was appropriate to seek medical support.

The service employed an activites co-ordinator who worked Monday to Friday within the home. People we spoke with told us that if there was an event on at the weekend, such as a summer fayre, then the activites co-ordinator would be there. We saw there was a variety of different activities for people living at Laurel Court displayed on a large, weekly planner in the foyer. There were also photographs from past events on display, including a visit from Zoolab in March 2016. The activities co-ordinator told us that residents had enjoyed the session and had requested another event which was booked for early June. People we spoke with told us they joined in with activities if they wanted to participate. Some people expressed a wish to access activities in the community, for example swimming and shopping.

On the first day of our inspection we saw people from a local group called 'Motivation and Co.' visited each floor of the service and undertook a variety of different activities. These included quizzes and arm chair

aerobics. People appeared to be enjoying this as we saw those sitting in the lounge all joined in as best they could. Those who were unable to join in, or chose not to participate, watched and looked happy as they were smiling. There was a friendly, pleasant atmosphere.

People's spiritual needs were met through a variety of ways. Care plans recorded people's values and beliefs and people were encouraged to maintain their faith. They also recorded how and when they would like to attend a service. The home had a chaplain who visited on the first day of inspection. We observed that people who wanted to joined in with saying grace before receiving lunch.

We saw that people using the service were keen to talk to the chaplain and the service held in the home during the afternoon was well attended. The manager told us how the chaplain was actively working with other denominations, with an evangelical service held once a month in the home. The home was also exploring a service specific to those people with dementia. This meant that the home was committed to meeting the spiritual needs of people from all faiths living at Laurel Court.

We saw staff responded to people's needs in a timely manner. If call bells were pressed we observed staff attending to them with minimal delay.

Meals on the dementia units were served on brightly coloured plates and bowls. These were used to support people with dementia as the colours were a contrast to the food served on them. We also noted the use of dementia friendly signs indicating to people where the lounge, dining room and bathrooms were. This showed the service was responding to people's needs by ensuring the environment was adapted to meet the needs of those living in the home and to support them to remain as independent as possible.

The complaints procedure was available for people living in the home and their relatives. People told us that they knew how to complain. One person we spoke with told us, "I would complain to [unit manager] or to the manager but I have never had to complain." Another person told us that their relative had complained on their behalf as some bathroom equipment needed replacing and said, "I'm still waiting for a new one." When we checked in the en suite bathroom we saw that the item had been changed and a new one was in place. We saw evidence that the manager responded to complaints in several ways using emails, telephone and verbal communication. A recent complaint about clothes going missing had been made in April and acknowledged within a short timescale. A meeting had been held with the complainant and resolved with a response by the provider on 31st May 2016. The outcome of the complaint documented that the '[relative] says there has been much improvement.'

Requires Improvement

Is the service well-led?

Our findings

The manager of the home had been in post since April 2016 and was applying for the position of registered manager a the time of our inspection. Feedback we received about the management of the home was positive from residents, staff and professionals. The provider had the CQC report from the inspection undertaken in September 2015 on display in the foyer. We could see that they had addressed aspects of the non compliances and shortfalls identified at the previous inspection and had outlined these for people, relatives, visitors and staff to see.

We asked staff for their views on leadership at the home. One member of staff told us the manager was 'very approachable as a manager.' Another told us, "They've got some great ideas;" and a third staff member told us, "Yes, I do feel well supported." A relative was aware that resident and relative meetings were held on a regular basis and told us, "I think the next one is [on] 17th June." They also considered that all the unit managers and the home manager were approachable.

The manager explained how they had introduced a new fixed rota for all staff. This was a company –wide policy that should have been implemented by the previous manager. It provided staff with details of their working rota well in advance. We were told that not all staff had welcomed the new fixed rota and some staff had left the service as a result of the new practice. We were confident that the recruitment drive being undertaken by the provider would resolve these issues.

We saw there was a staff communication book, which allowed staff from each shift communicate and changes or request with other staff members who were not on duty. We also saw staff attended handover at the start of the shift; this was a room by room check and ensured that staff were aware of any changes which may have occurred since they were last on duty.

Head of Department meetings took place each week. These involved the manager, the deputy manager, the chef, the housekeeper and heads of units, including a maintenance representative. Information was shared about people coming into or leaving the home and any issues or concerns were discussed to see how these could best be resolved between groups of staff. Minutes of these meetings were circulated to all attendees.

Staff told us that staff meetings were in place and occurred on a monthly basis. We saw minutes of these meetings and topics for discussion included moving and handling, infection control, laundry and administering medicines. One staff member referred to the meetings as 'beneficial.'

There was a system in place to monitor accidents, incidents and safeguarding concerns within the home. The manager carried out a monthly trends analysis on information, such as accidents or incidents, occurring within the home. We saw that one person had been admitted to hospital in April for a psychiatric assessment following several incidents in the home. In May the home had instigated input from a psycho-geriatrician, following two safeguarding incidents on the dementia unit involving the same person. This meant that the home responded to accidents and incidents and took appropriate action to safeguard the

individual and other people, involving relevant professionals where necessary .

We saw that the home used a management system called 'You Comply' to report data to head office on a monthly basis. The report included information such as the number of falls; people who had lost in excess of 5 kilos in weight over a period of six months or more; pressure sores identified as grade 3 and above; and any safeguarding incidents. This meant that the manager had oversight of clinical issues in the home as well as safety concerns and could track that these were followed up and acted upon.

We looked at the audit systems in place to monitor the service. Checks of finances, medicines administration, infection control, support plans and health and safety were undertaken by senior staff on a weekly or monthly basis. These were also audited by external management to verify that the checks were correct. We saw that medication audits were in place and the service had improved, achieving over 90% in the last audit. Any actions required identified as part of the audit had been logged and dated when completed. The manager told us that a score of under 90% would result in additional spot checks of medication being introduced. This showed us that the provider had oversight of the safety and quality of the service. This meant that at the time of our inspection there were well-managed systems in place to monitor and assess the quality of the care provided and quality audits were completed in line with company policy.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Spillage of clinical waste from open yellow bag in unlocked slice room and inappropriate storage of new continence products - with reference to 12 (2)(h).