CCA & Mrs C Bolland

Laurel Mount

Inspection report

Woodville Road
Keighley
West Yorkshire
BD20 6JB

Tel: 01535667482

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Laurel Mount provides accommodation for up to 34 people who require nursing care. The home is situated in large gardens with accommodation spread over two floors. It is located in Keighley in West Yorkshire.

The inspection was unannounced and took place on 1 February 2016.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who used the service and relatives all told us the home provided appropriate care that met people's individual needs. They all said people were treated well and that people were safe in the home.

Medicines were managed safely. People received their medicines at the time they needed them and appropriate records were kept.

Staff understood how to identify and act on allegations of abuse. Safeguarding procedures were in place and we saw evidence they had been followed to keep people safe. People told us they felt safe in the company of staff and did not raise any concerns.

The premises were safely managed. It was decorated to a high standard with ongoing refurbishment to replace areas of tired décor. Appropriate checks on safety systems such as gas and fire took place.

There were sufficient staff employed to ensure a good level of care and support was provided to people. Safe recruitment procedures were in place to ensure staff were of suitable character to work with vulnerable people.

People told us staff had appropriate skill and knowledge to care for them and staff displayed a good knowledge of the people they were caring for. Staff received a range of training; however the provision of refresher training lacked structure which meant people received training updates at inconsistent intervals.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Improvements were required to evidence that the service was fully acting within the legal framework of the Mental Capacity Act (MCA) with regards to making best interest decisions.

People spoke positively about the food at the home. We saw menus ensured a variety of food was provided. Staff were attentive to ensure people had a positive dining experience and were kept sufficiently hydrated throughout the day and their mealtime nutritional input supplemented by snacks. However nutritional screening was not always correctly completed which meant there was a risk that appropriate action was not

taken t following weight loss.

People had access to a range of health professionals to help ensure their healthcare needs were met by the service.

Staff treated people well displaying a high level of dignity and respect. It was clear staff and the registered manager had developed strong relationships with people and were dedicated to providing attentive care.

Information was present on people's likes, dislikes and preferences and staff knew these preferences well.

People told us the service met their individual needs. We saw examples of care and support delivered in line with people's plans of care. However we found some care plans were not present or sufficiently robust. This meant there was a risk of inconsistent care and support being provided.

People were provided with a range of activities and social opportunities.

A system was in place to record and respond to complaints. People we spoke with told us they were highly satisfied with the service and did not raise any concerns or complaints.

People and staff told us the service was well managed. They said there was a nice and friendly atmosphere in the home and the registered manager was visible and involved in care and support.

Systems were in place to monitor the quality of the service and help ensure continuous improvement of the service and learning from incidents.

We found one breach of the Health and Social Care Act (Regulated Activities) Regulations 2014. You can see what action we asked the service to take at the back of this 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?

Good

The service was safe.

Medicines were managed safely and people received their medicines as prescribed.

There were sufficient number of staff deployed to ensure safe care. Safe recruitment procedures were in place.

People told us they felt safe in the home. Risks to people's health and safety were assessed and monitored.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People and their relatives told us staff had the right skill and knowledge to care for them. More structure was needed to staff training and supervision.

People told us the food was good and we saw it looked appetising with sufficient variation and choice. We found nutritional screening tools were not consistently used in the correct manner.

People had access to a range of health professionals to help meet their healthcare needs

Is the service caring?

Good

The service was caring.

People and their relatives all said staff were friendly and treated people well. We observed staff treated people with dignity and respect and had a high regard for their wellbeing.

Staff had developed good relationships with people and understood their individual needs and preferences.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and their relatives told us that people received appropriate care that met their individual needs. However care plan documentation did not always contain sufficient information to guide staff in delivering consistent care.

A range of social activities was available to people.

The service had a low level of complaints and all the people we spoke with told us they were satisfied with the service.

Is the service well-led?

Good

The service was well led.

People and their relatives told us there was a good atmosphere within the home and staff and people got on well. Staff reported that they enjoyed working at the home and morale was good.

Systems to monitor and improve the quality of the service was in place. The manager was committed to further improvement of the service.

People's feedback was regularly sought and their views used to make changes to the service.

Laurel Mount

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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 1 February 2016 and was unannounced. The inspection team consisted of three inspectors.

We used a number of different methods to help us understand the experiences of people who used the service. We observed care and support within the communal areas of the home. We spoke with six people who used the service, five relatives, the registered manager, the nurse on duty, three care staff and the cook. We also spoke with one health professional who worked with the service. We also spoke with the local authority to get their views on the quality of the service.

We looked at seven people's care records and other records which related to the management of the service such as training records and policies and procedures.

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider, notifications and requesting information from the local authority. Prior to the inspection, we asked the provider to complete 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. This was accurately completed and submitted to us promptly.

Good

Is the service safe?

Our findings

People told us they felt safe in the home. They described staff as "nice" and "friendly." The relatives of people who lived in the home told us they had no concerns about people's safety.
We observed interactions and saw people appeared comfortable and relaxed in the company of staff, with staff engaging people in conversation and making them smile.

Staff spoken with understood what abuse was and were aware of how to report any concerns about people's safety and welfare. The registered manager had a copy of the West Yorkshire Safeguarding Procedures and was aware of how to follow them. A safeguarding log was in place which provided information on the number of safeguarding incidents identified by the service. We saw there had been a low number of safeguarding incidents within the service. This was confirmed by people and staff we spoke with who told us they had not seen anything of concern. Where safeguarding incidents had been identified we saw they had been investigated and where possible preventative measures put in place to help prevent a reoccurrence.

Risk assessments were in place to manage risks to people's safety and welfare such as falls and pressure sores. When people were identified as being at risk of developing pressure sores we saw action was taken to reduce the risk, for example by providing pressure relieving equipment such as mattresses and cushions.

We looked at how people's medicines were managed and found people's medicines were managed safely and properly. People we spoke with told us they received their medicines on time. One person told us, "They don't let you suffer, give me medication when I need it."

There were policies in place which were in line with the NICE (National Institute for Health and Care Excellence) guidance on managing medicines in care homes. Medicines were stored securely within a locked room. Medicines classified as controlled drugs were stored correctly and a medicines fridge was available for medicines that required refrigeration. We carried out a random stock check on the controlled drugs and found the stock balances corresponded with the information in the controlled drugs register.

The home used a monitored dosage system, (MDS) and most people's medicines were supplied within this system. Each medicine was dispensed separately in blister pack containing 28 days' supply and different coloured blister packs were used for different times of the day. This enabled stock checks to be carried out quickly and helped to make sure any errors were identified and acted on quickly.

We looked at the medication administration records, MARs and found medicines were signed for when they are administered. However, on three people's MAR charts we found some medicines had been added or changed and the handwritten entries had not been signed by two staff. It is good practice for two staff to sign any handwritten entries on the MAR to reduce the risk of errors in transcribing the information. This was discussed with the registered manager who provided an assurance they would deal with it immediately.

Some medicines have special instructions about how they should be given in relation to food. We found

there were suitable arrangements in place to make sure these medicines were administered in accordance with the instructions. When medicines are prescribed to be taken "as and when needed", (PRN) it is good practice to have guidance in place to tell staff when the medicines should be given. The guidance is commonly referred to as a "PRN protocol". We found PRN protocols were in place where indicated.

The registered manager told us no one using the service at the time of the inspection was receiving their medicines covertly, that is in a hidden or disguised format, and no one administered their own medicines.

The registered manager told us the supplying pharmacist carried out audits of the medicines management systems at least once a year and provided support and advice as needed. They told us they aimed to have people's medicines reviewed every six months if possible and said the pharmacist was supporting this process by liaising directly with people's GPs. We saw evidence of medication reviews in people's care records. The registered manager told us the nursing staff that were responsible for administering medicines had annual competency checks to ensure safe practice.

We concluded there were sufficient staff to ensure safe care. People and staff we spoke with told us there were enough staff in the home. For example one person told us, "Staff come quick when you press the bell" and another person said, "Plenty of staff." A relative told us, "There's always plenty of ladies walking around." We spoke with the registered manager who told us that staffing levels were based on occupancy levels and people's individual needs. They told us that in recent weeks five care workers had been on duty during the day. One nurse was always on duty, with the registered manager working as an additional nurse on around five days a week. The registered manager assisted with care and nursing duties as well as completing audits and other paperwork. On the day of the inspection, two additional people moved into the home and in response to this, the manager had ensured six care workers were rostered to be in place during the day. This showed the home adapted staffing levels to people's individual needs. At night two care workers and one nurse was on duty. Ancillary staff such as cleaners, cook and a maintenance worker were employed. People who used the service and relatives spoken with did not raise any concerns about the availability of staff.

On the day of the inspection, the home was one care worker short due to last minute sickness. As a result staff were very busy, however people were not left without care and assistance for long periods of time. This was reflected in some of the comments we received for example one person told us, "Usually quick but took a bit longer this morning." We concluded planned care levels were sufficient to ensure people received a good level of care and support. Rotas showed that on most occasions planned staffing levels were achieved. We saw a stable staff team was employed with a low number of agency staff used which helped ensure staff were familiar with people's individual needs.

Safe recruitment procedures were in place. These included ensuring people completed an application form detailing their previous employment and qualifications. Candidates were required to attend an interview. Sufficient checks on people's backgrounds took place including ensuring a Disclosure and Barring Service (DBS) check and references were undertaken. In one staff member's file we noted there was no evidence of any identity checks. We asked the manager to ensure care was taken to retain all documents in the future. We checked a sample of nurse pin numbers and found them to be correctly registered to practice.

The premises were safely managed. Rooms were pleasantly decorated with people encouraged to personalise rooms with their own possessions. The home was maintained appropriately. New carpets had recently been provided in the communal areas and further refurbishment and improvement was planned to individual bedrooms. Radiators were covered to help prevent burns. Window openings were restricted to reduce the risk of falls. A number of communal areas were present where people were able to spend time.

This included five lounge areas and a large garden.

Regular checks took place on water outlets to reduce the risk of scalding. Checks on the gas and the fire safety system took place. We did find that the fire risk assessment was out of date and required a review. We asked the registered manager to ensure this was updated.

The building was kept clean and hygienic and there were no offensive odours. One relative told us, "The room is always clean and odour free, never any unpleasant smells in the home." The service had recently achieved a three star food hygiene rating from the local authority. The registered manager told us about some of the improvements they had made following that inspection to achieve a higher score in the future. Checks on bedrooms and bathrooms took place to ensure they were kept in a hygienic state. The local authority infection control team last visited the service in 2014 and the service scored 95% with the lack of provision of hand towel dispensers being the main issue. The registered manager told us they were working with the provider to address this.

Emergency arrangements and procedures were in place. This included personal evacuation plans which detailed how to evacuate people safely in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

People and relatives we spoke with told us staff had appropriate skill and knowledge to provide effective care. They said staff were experienced in their role and understood people's individual needs. We saw there was a low turnover of staff with many working at the organisation for several years. This had allowed good relationships to develop between staff and people who used the service. Staff we spoke with demonstrated a good knowledge of the people and subjects we asked them about. Staff told us they felt well supported and had received appropriate training.

New staff were required to complete the Care Certificate. This ensured new staff were provided with a broad range of training which met recognised standards. Staff also received a local induction to the home and the policies and procedures they were expected to follow. Staff were encouraged to attain further qualifications in Health and Social Care and we saw evidence many staff had achieved these.

The service had a contract with an external training company to provide a range of training. This was a mixture of distance learning where staff undertook learning, completed a workbook and had their competency assessed. This was complimented by several face to face training sessions. There had been a recent focus on providing face to face training in manual handling and Mental Capacity Act (MCA).

However there was a lack of structure to training updates with some staff receiving training updates at inconsistent frequencies. For example a number of staff had not received safeguarding training for nearly four years, and there were inconsistencies in the provision of infection control and health and safety training. Training was not underpinned by any training needs analysis. Some staff had received recent supervision as well as a thorough competency check on their practice. Whilst we found this process was thorough, it had not been consistently applied, with some staff having not receiving a recent competency check or supervision. The registered manager had already recognised that additional training and supervision was required for some staff and told us they were taking steps to address.

Specialist training had been provided to some staff such as diabetes management and catheter care.

People and their relatives told us the food was good within the home. For example one person told us, "They feed us well". The service had obtained information on people's culinary likes and dislikes, preferred portion size and any special requirements. This helped ensure the service met their individual needs. At breakfast time, people had a choice of a hot breakfast such as sausages and bacon, cereals or toast. At lunchtime, the main meal was served. There was one option, however if people did not like it an alternative was provided.

We observed support at mealtimes. We heard people being offered second helpings at breakfast time to ensure they did not go hungry. We observed drinks were served in the morning and afternoon and there were drinks available for people all day. In all the bedrooms we visited we saw people had jugs of juice. A visitor told us their relative, who stayed in their room, always had a jug of juice nearby.

We observed the lunchtime meal and saw it was served in a pleasant atmosphere with staff chatting to people as well as providing support. The food looked appetising and smelt good. Staff supported some people to eat, and were patient with them, allowing them time to chew and swallow each mouthful and asking if it was the right temperature for them. Where people were on a soft diet we saw staff took care to ensure this was provided.

Catering and care staff were aware of people's individual requirements for example those that needed their food pureed or drinks thickening and those who needed to ensure a low sugar intake. This provided us with assurance that people received appropriate food that met their individual needs. Where food was blended each individual element was blended individually where possible so people could experience the individual preferences.

We saw one person had a thickening powder which was to be added to their drinks to reduce the risk of choking. We found the instructions were clearly recorded on the MAR chart and in the person's care plan and staff we spoke with knew how much of the thickening powder to add to get the required consistency.

People had care plans in place to show how they should be supported to meet their nutritional needs. However, we found the information in the care plans did not always provide enough detail. For example, the care plans referred to people having an "adequate" fluid intake but did not make it clear what this was. We asked one of the care assistants about the support one person needed with eating and drinking. They told us they were trying to encourage the person to have eight glasses of fluids in a day. They said the person did not like hot drinks. However this information was not in the person's care plan.

We saw people's weight was checked and when there was unplanned weight loss action was taken. For example, we saw people's GPs were informed and asked to prescribe dietary supplements. People's risk of malnutrition was assessed using the MUST (Malnutrition Universal Screening Tool). However, we found the MUST tool was not always used correctly. In one example, the MUST for the person had been incorrectly calculated and as a result the extent of recent weight loss had not been identified. Although the person was not yet classed as underweight, following the weight loss the service had not taken action in line with MUST guidance by ensuring a plan to increase their nutrition was put in place and/or contact relevant health professionals made. In another example the person's MUST assessment we saw they had lost just over 6kg in the last three months which equated to more than a 10% weight loss. However, this had not been included in the MUST assessment which meant the overall score was incorrect. The manager agreed to review completion of MUSTs with nursing staff to ensure an accurate record of each service user was kept.

This was a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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). DoLS requires care homes to make applications to the local authority where they suspect they are depriving people of
their liberty.

The manager had been on detailed DoLS training provided by the Local Authority. The registered manager had put DoLS applications in for seven people who lived at the home. Scrutiny of people's care records demonstrated that all relevant documentation had been completed. These applications were all waiting for assessment by the supervisory body. The manager had a good understanding of the DoLS process, had assessed people's capacity and ensured applications were not made for those deemed to have capacity. This showed a good understanding of the process. We saw care was delivered in the least restrictive way possible with people having free access around the various communal areas in the home.

We found documentation evidencing best interest decisions needed to be more robust. For example we saw that where bed rails had been provided, if the person had been assessed to lack capacity, consent was signed for by the relative rather than their opinion being considered as part of a best interest decision. We saw a lack of evidence that decisions such as flu vaccinations were made as part of a best interest process. Some mental capacity assessments were in place but these were generic rather than decision specific. Mental Capacity assessments should only assess a person's capacity to make a specific decision.

People told us their choices were respected such as where they wanted to sit within the home. Some people preferred a quieter environment and their needs were catered for as there were a number of quieter communal lounges.

People said that they had access to healthcare professionals for example one person told us how the service had taken prompt action when they had got a cough. People's records showed they had access to GPs and a range of NHS services such as district nurses, tissue viability nurse specialists, speech and language therapists, diabetic nurse specialists, dentists and chiropodists. We spoke with a visiting health professional who told us the service provided good care and liaised with them appropriately.

Good

Is the service caring?

Our findings

People all spoke positively about the care and support provider. They all said they were treated with dignity and respect by staff. Comments included, "Carers look after me well, couldn't ask for better," "Nice staff, all nice, they take me out," "I feel happy here. Everyone seems to be having a laugh" and, "Within a week they had all learnt my name. It's very personal." A relative told us, "We'd visited a lot of places before we came here and as soon as we walked in, we knew this was the place" and another relative told us "The nurses are lovely with her." A third relative told us that the service always ensured they treated their relative with dignity and respect and gave an example of when they had spilt a drink on some clothing, this was attended to promptly and discretely by staff.

We observed care and support in the communal areas of the home. Staff treated people kindly and took action to reduce any distress. Staff respected people's privacy for example knocking on doors before entering. People were offered appropriate assistance at mealtimes to ensure their dignity was maintained. People appeared comfortable and well presented. At lunch time we observed staff supported people discreetly and sensitively. They sat with people encouraging them to eat and where necessary helped people with their food. Call bells were within easy reach of people so they could summon assistance if they needed it. People looked clean and tidy with brushed hair and clean well fitted clothes. This indicated that people's personal care needs were met by the service.

Steps were taken to ensure people received personalised care and support. For example one person liked to sit in a particular place in one of the lounges. Staff had hung a photograph of their wedding day on the wall so that the person could admire the photo whilst they sat in the lounge.

When staff spoke to people they used their preferred name and spoke gently and respectfully. There was a high staff presence with staff constantly checking on people's wellbeing and needs and checking if they needed anything.

Dignity, respect and the attitude of staff was monitored through the annual satisfaction survey, staff supervisions and also on an informal basis by the registered manager who was regularly visible and assisted with care and support.

Personalised information had been gathered on people who use the service for example their culinary likes and dislikes. Staff we spoke with had a good understanding of the individual needs and preferences of the people they were caring for. People and relatives told us they felt listened to by the service. They said the registered manager was very receptive to their comments and suggestions. During observations we saw staff asked questions and listened to people, for example before assisting with personal care. Choice was offered as to where people wanted to eat their breakfast and lunch and we saw people's preferences were respected. Where people could not communicate verbally we saw staff understood people's non-verbal body language and responded appropriately.

We saw people were encouraged to maintain their independence where possible, through participation in

activities and staff encouraging people to eat as independently as possible. Relatives told us this was the case for example one relative said "They try to encourage her to eat for herself and assist if she is struggling."

The home took steps to identify those who were at the end of their life and made appropriate arrangements to ensure they received a dignified death. We did find some end of life care plans required more personalised information, the registered manager told us they had started to do this.

There were no restrictions on visitors to the home. We noted staff were very welcoming to visitors making them feel comfortable and involved.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives all told us that appropriate care was provided that met people's individual needs. For example one person told us that the care was personalised and, "It's the little things they do that make it different." People told us staff responded to their calls for assistance and provided appropriate care and support. One relative told us how they were very impressed with the information requested by the home before their relative was admitted; they said they thought this resulted in staff being aware of their relatives, needs, likes and dislikes.

During observations of staff practice and discussions with staff we found staff had a good awareness of people's individual needs and how to meet them. However care records did not always reflect a full assessment of people's individual needs. This meant there was a risk that inconsistent care and support would be provided and did not support fully consistent and responsive care.

A pre-admission assessment process was in place. The registered manager carefully assessed people's needs prior to admission to determine whether the service could meet their needs.
This was done to make sure the home had the right resources to meet people's needs. We looked at the records of one person who had moved into the home shortly before the inspection. We found their needs had been assessed however this information had not been used to develop an initial plan of care. This created a risk of people not receiving the right care and support when they first moved in. The handover notes contained some basic information about the person's needs and when we looked at the daily care notes we found the night staff had not made any records about the care and support provided to the person during the first night in the service. This was discussed with the registered manager. We spoke with one of the care assistants who said they had been told about the person's needs at the morning handover. However as this information had not been formally put into an initial plan of care there was a risk that inconsistent care and support would be provided.

In other people's records we saw a nursing needs assessment was completed around the time they moved into the home. In two people's care records the nursing needs assessments were not dated or signed and therefore it was not clear how soon after admission they had been completed.

We found other examples where the lack of information could lead to inconsistent care and support. It wasn't always clear in people's individual care records what the correct setting was for the pressure relief mattresses. However, the registered manager told the checked people's weights every month and then checked the mattresses to make sure they were set correctly.

In one person's records we saw they needed the support of a hoist to be moved. However, their moving and handling assessment had not been reviewed since 29 January 2014 and the moving and handling plan did not make any reference to the use of a hoist.

One of the care assistants we spoke with told us how they supported people who had catheters in place. For example, they told us they changed the catheter bags every day and dated them. However, this information

was not in the care plans.

In the care records of one person who had diabetes we found detailed information to guide staff on the actions they should take if their blood sugar levels were too low or too high. However, another person's care plan did not have this detail. The care plan referred to a "stable" blood sugar but did not give any indication of what that was for that particular person.

This was a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Relatives told us they were fully involved in care and support decisions. However some care plans contained a lack of evidence that people and their relatives had been involved in regular reviews of their plans of care.

The home used the Pressure Ulcer Safety Cross scheme to monitor the occurrence of pressure areas within the home. We saw there had been no pressure areas identified in January 2016, and on reviewing records and our own notifications, we found there was a low occurrence historically. This provided us with assurance that appropriate pressure area care was provided. We saw the service was responsive in providing additional equipment where risks were identified. For example specialist mattresses. One person told us how the manager had helped them obtain a wheelchair which they found very comfy.

There was information about people's past lives and interests in the care plans. Staff we spoke with were able to tell us about people's needs and their likes and dislikes.

Handovers took place between shifts so that any changes in people's needs could be identified and passed on.

People who lived at the home and relatives generally told us there was enough to do within the home. Staff were able to give us examples of how they ensured a range of activities and social opportunities took place to meet people's individual social and spiritual needs. One person told us how the home took them out to the local town where they often ate out. An activities co-ordinator was employed who worked at the home four days a week. Records showed evidence that people were involved in a range of activities including singing, games and a visits from a variety of external entertainers who delivered interactive sessions.

People told us they were happy with the service for example, one person told us, "I have no complaints, but if I did will tell the manager, she is very understanding." The complaints procedure was displayed in the entrance to bring it to the attention of people who use the service. Speaking with people and relatives and reviewing quality questionnaires we concluded people were highly satisfied with the service and had no need to complain. We saw no complaints had been received by the service in recent years. Prior to the inspection we reviewed intelligence held on the provider. No complaints or concerns had been reported to the Commission in recent years. We saw a number of compliments had been received about the service, these were retained so the service knew the areas where it exceeded expectations.

Good

Is the service well-led?

Our findings

A registered manager was in place. The service had submitted statutory notifications such as allegations of abuse, injuries and deaths to the Commission. This helped us to monitor events occurring within the service.

All the people and relatives we spoke with said they were happy with the quality of care provided. They all said they would recommend the service to others. One person told us, "[Registered manager] is very good, doesn't let you suffer." The person went on to say how they were very impressed with the registered manager's in-depth nursing knowledge.

We observed a pleasant atmosphere within the home with the staff team where staff and people knew each other well. A number of people and relatives praised the "family type atmosphere" and said this was the reason they liked the home so much. They said this helped ensure personalised care and support was provided. People and their relatives all praised the registered manager. They described the manager as very hands on and said they took a keen interest in day to day running of the home. People and their relatives told us they knew the manager by name and felt they could go to them with any issues. During the inspection we saw the registered manager was highly involved in care and support for example assisting people to eat at lunchtime. People and relatives we spoke with confirmed this was a regular occurrence.

Staff told us morale was good and that they felt well supported by the registered manager. They said they were able to go to them with any issues.

Systems were in place to assess and monitor the quality of the service. Audits took place in areas such as medication, incidents & accidents, hand hygiene, mattresses and hospital admissions. We saw evidence these had been effective in identifying and rectifying issues. Information on a number of quality indicators was submitted to the local authority on a three monthly basis as part of a system to monitor quality.

The manager demonstrated a commitment to continuous improvement of the service. They told us how they had read CQC inspection reports to identify common shortfalls in similar services. We saw evidence this had been a useful mechanism for making improvement for example to aspects of the medicine management system. External expertise was sought in some areas as part of a system to ensure continuous improvement of the service. For example medication audits had been carried out by a pharmacy to provide specialist expertise in the area of medicines management. On reviewing the Provider Information Return submitted to us several months before the inspection, we saw the service had achieved some of their planned improvements for example in providing staff with face to face Mental Capacity Act training and replacing carpets.

The manager was aware of the current shortfalls in the service and where further improvement was needed. For example they had recognised that care plans, "Required an overhaul" and was in the process of beginning to make these improvements. They recognised that improvements to the consistency of staff supervision and appraisal was needed.

A system was in place to record and investigate any incidents that occurred within the service.
The number of incidents and accidents was analysed periodically to look for any trends and themes. We saw there were generally low numbers of incidents with no concerning themes or trends identified. There was evidence that action was taken to prevent re-occurrences however documentation relating to the preventative measures put in place could have been more robust.

People's feedback was sought through the annual satisfaction survey. We looked at the recent results which had been analysed by the service. These provided more evidence that people were highly satisfied with the service and did not have any concerns or complaints. Comments included; "Laurel Mount has a good atmosphere, it feels friendly and warm", "My mum is very well looked after, can't find fault with her care or the nursing staff" and "Friendly homely atmosphere makes the home very welcoming, staff always helpful and supportive." We saw where minor issues had been reported previously these had been addressed. For example one person remarked that activities and stimulation within the home had now improved following previous feedback.

A set of policies and procedures was in place. We did note that the admission policy was not very clear; it stated admission documentation should be completed before relatives left as they may have valuable information to contribute. It wasn't clear what documentation this was referred to, there was no information to guide staff on the use of initial care plans or how soon care plans should be developed after admission.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Regulation 17 (1) 2(c) A complete record of each service users care was not present.