Croft Carehomes Limited

Laughton Croft Care Home with Nursing

Inspection report

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Date of inspection visit:
27 October 2016

Date of publication:
30 December 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We last carried out an unannounced comprehensive inspection of this service on 25 February 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this follow-up comprehensive inspection to check that they had followed their plan and to confirm that they now met legal requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Laughton Croft Care Home with Nursing on our website at www.cqc.org.uk. In addition we had received information of concern about the standards of care provided at Laughton Croft Care Home with Nursing.

This inspection took place on 27 October 2016 and was unannounced.

Laughton Croft Care Home with Nursing is registered to provide accommodation and nursing and personal care for up to 36 older people and people living with either dementia, a physical disability, sensory impairment or a mental health problem. There were 21people living at the service on the day of our inspection. The service has two units; Ruby and Emerald.

The recently appointed manager had commenced the process to register with the Care Quality Commission (CQC). A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in February 2015 we asked the provider to take action to ensure that people were protected from the risk of infections, that people were protected from the unsafe management of medicines and that the provider operated effective systems and processes to make sure that they assessed and monitored their service. The provider sent us an action plan on 4 July 2016 and told us that these actions had been completed. On this inspection we found that the provider had made the required improvements and was no longer in breach of the legal requirements.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect them. The management and staff understood their responsibility and made appropriate referrals for assessment. One person at the time of our inspection had their freedom lawfully restricted under a DoLS authorisation and two people were waiting for a DoLS assessment.

People were protected from avoidable harm and abuse and had their risk of harm assessed. Staff were

aware of the signs of abuse and knew how to escalate their concerns. There were sufficient staff on duty to keep people safe and meet their care needs. People received their medicine safely from staff that were competent to do so. People were cared for in clean and well decorated environment by staff who understood good infection control practices.

People received effective care from skilled and knowledgeable staff who received training to meet people's care needs. Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and were able people were asked for their consent to care. People received a balanced and nutritious diet and drinks and snacks were provided between meals. Staff ensured that when there were changes to a person's health that they were referred to the most appropriate healthcare professional.

People were cared for with kindness and compassions by committed and caring staff. Staff involved people and their families in decisions about their care. People were cared for by staff who respected their privacy and dignity.

People received care that was personal to their individual needs. Some people were supported to take part in activities such as colouring or listening to music. However, the provision of purposeful and meaningful activity was limited to a few. People were confident that their concerns and complaints would be actioned and responded to in a timely manner.

The culture of the service had improved. The recently appointed manager was approachable and staff felt empowered. There have been improvements in the quality monitoring of the service through audit and feedback from people who lived in the service and staff.

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.

There were always enough staff on duty to meet people's needs.

Competent staff followed correct procedures when administering medicine.

Staff had access to safeguarding policies and procedures and knew how to keep people safe.

A good standard of cleanliness was maintained throughout the service.

Is the service effective?

Good

The service was effective.

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were cared for by staff that had the knowledge and skills to carry out their roles and responsibilities.

People were supported to have enough to eat and drink and have a balanced and nutritious diet.

People had their healthcare needs met by appropriate healthcare professionals in a timely manner.

Is the service caring?

Good

The service was caring.

Staff had a good relationship with people and treated them with kindness and compassion.

Where able people were involved in decisions about their care.

People were treated with dignity and staff members respected their choices, needs and preferences.

Is the service responsive?

Good

The service was responsive.

People were encouraged to maintain their hobbies and interests.

People's care was regularly assessed, planned and reviewed to meet their individual care needs.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had recently introduced regular quality checks to help ensure that people received safe and appropriate care. Although, further work was needed in this area.

The service had been without a registered manager for over a year.

The recently appointed manager had introduced an open and positive culture which focussed on people and staff.

Laughton Croft Care Home with Nursing

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.'

The inspection took place on 27 October 2016 and was unannounced. The inspection team was made up of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection, we also looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about and concerns raised by members of the public and staff. We also reviewed information sent to us by the local authority who commission care for some people living at the home, and information from others professional bodies such as Fire & Safety and Public Health.

During our inspection we spoke with the recently appointed manager [the manager], the registered nurse, a senior member of care staff, five members of care staff, the cook, two housekeepers, the activity coordinator and five people who lived at the service. We also observed staff interacting with people in communal areas, providing care and support.

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

We looked at a range of records related to the running of and the quality of the service. These included two staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the

provider completed. We also looked at care plans and daily care records for 11 people and medicine administration records for six people.

Good

Is the service safe?

Our findings

At our inspection in February 2015 we identified that people were not adequately protected against the risks associated with the unsafe use and management of medicines. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 (f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After our inspection the provider wrote to us and told us what they had done to meet the legal requirements. At this inspection we found that actions had been taken to meet their legal requirements and the provider was no longer in breach of the regulation.

People who lived in the service received their medicine from staff that had received training in medicines management and had been assessed as competent to administer them. At lunchtime we observed medicines being administered to people and noted that appropriate safety checks were carried out and the administration records were completed once the person had safely taken their medicine. We observed that the registered nurse supported people to take their medicine in a calm and professional manner. For example, they provided reassurance and praise to one person who took their medicine to help their breathing through a special breathing aid.

People told us that they were confident with the way staff looked after their medicines and that they received them on time. One person who needed regular medicine for a long term medical condition said, "I have quite a few tablets to take. A nurse does all that. I get them in the morning, in the evening and last thing at night on time." Another person told us, "They [registered nurses] deal with all that and no problems and on time."

We looked at medicine administration records (MAR) for six people and found that medicines had been given consistently and there were no gaps in the MAR charts. Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. For example, "prefers to take with a spoon" and "inform GP if refuses medicine four or more times." Where a person did not receive their medicine a standard code was used to identify the reason, such as when a person was asleep. We saw where a person received their medicine covertly; that is mixed, with their food that all necessary checks had been completed and staff had involved their GP, pharmacist and family and had acted in the person's best interest.

All medicines were stored accordance with legal requirements, such as locked cupboards, medicines trolleys and fridges. There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned promptly. Staff had access to guidance on the safe use of medicines and the medicines policy. A registered nurse told us that all medicine incidents were reported through a formal route and that the manager investigated them and took action to reduce the risk of harm to people. For example, recently the medicine fridge thermometer provided false readings. There was a risk that medicines may not be stored at the correct temperature to keep them effective. Therefore a new thermometer was purchased.

At our inspection in February 2015 we identified that people were not adequately protected against the risk of acquiring an infection. This was because the provider did not maintain appropriate standards of cleanliness and hygiene. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After our inspection the provider wrote to us and told us what they had done to meet the legal requirements. At this inspection we found that actions had been taken to meet their legal requirements and the provider was no longer in breach of the regulation.

People who lived at the service told us that the premises were kept clean. One person said, "They are always doing the floors and that and if you want any clothing washing they do that, no problem". Another person showed us their bedroom that we saw was clean and they told us, "While I'm having my dinner [in the dining room] they usually come in and give it a good clean." Members of staff also shared with us that the premises were clean. A registered nurse said, "At present it's clean, cleaner than before. Staff [housekeepers] are aware now, aware of their job. This depends on the manager. [The manager] supervises the housekeepers, and gives feedback from their [daily] walkabout. I also now feel able to feedback to the housekeepers." The housekeeping improvements included a cleaning schedule and log for daily and weekly cleaning tasks for each bedroom and shared area. The housekeepers had a daily catch-up and the head housekeeper shared any concerns or issues with the manager. As we walked about the service we saw that all areas were clean, there were no offensive odours, staff had access to protective equipment and moving and handling equipment was maintained and stored properly.

The manager had introduced a leadership role for infection control and two members of staff were responsible for attending link meetings with the local authority and sharing best practice guidelines with all staff. One member of care staff told us about their role and said, "I attended a meeting on sepsis. It's relevant to our clients. We've now updated our care plans with a check list to identify if anyone is at risk of sepsis." We also found that the infection control leads were involved in training new staff and agency staff in hand hygiene and cleanliness.

People told us that they felt safe living in the service. The provider had policies and procedures in place to support staff to prevent people from avoidable harm, potential abuse and help keep them safe. Staff told us that they had received training on how to keep people safe, how to recognise signs of abuse and how to report their concerns. One staff member said, "I would report to the manager or go straight to safeguarding."

There were systems in place to support staff when the registered manager was not on duty. Staff had access to contingency plans to be actioned in an emergency situation such as a fire or electrical failure. Staff had access to on-call senior staff out of hours for support and guidance.

People had their risk of harm assessed. We found that a range of risk assessments had been completed for each person for different aspects of their care such as swallowing and mobilising safely. Care plans were in place to enable staff to reduce the risk and maintain a person's safety.

There were environmental measures in place to keep people safe. For example, internal fire doors had automatic closures which were activated if the fire alarm sounded. All external doors were securely locked with key pads; however some people were assessed as able to have the key pad codes to come and go as they wished. The corridors had hand rails situated at an appropriate height and painted a different colour from the walls to help people recognise them. Furthermore, we found that shared areas and corridors were kept free from clutter so that people could move freely about the service without the risk of trips and falls.

We saw that accidents and incidents were recorded and that the manager of the service checked these and

noted what action had been taken. We could see that since the new manager had started, the actions to be taken were focused on the individual and that they considered how to prevent future similar incidents arising.

We found that there were sufficient staff on duty to meet people's needs and call bells were answered promptly. People told us that there were enough staff to look after their care needs and one person said, "I have a buzzer and they come straight away."

We looked at staff rotas for November 2016 and saw that agency staff were used to fill gaps. The manager told us that although they continued to rely on agency staff, that there were plans to recruit staff on a permanent basis. However, the manager ensured that the same agency staff supported the service to maintain stability and continuity of care for people who lived in the service. We looked at two staff files and saw that pre-employment checks were carried out, however on one file there was not a record that a check had been carried out with the Disclosure and Barring Service to ensure that the person did not have any convictions in their past that might give rise to concerns about the safety of people they worked with. Following our inspection the manager provided us with evidence that these checks had been undertaken.

Good

Is the service effective?

Our findings

We asked staff from all disciplines if their training supported them to carry out their role effectively, and they all responded positively. A staff member who had been employed at the service for a few months told us that when they started working at the service they undertook training in safety issues and general online training. In addition, they told us that although their role was not a caring one, their training provided insight into the care of people who lived at the service and their medicine management. They shared with us that they were undertaking a nationally recognised course in nutrition and were focussing on the preparation and presentation of pureed meals to improve the mealtime experience for people. Other non-care staff told us that they had undertaken training in caring for a person living with dementia. They explained the importance of this and one said, "It helps me understand and communicate with them better."

Staff had not received supervision for some time but since the new manager had taken up their post most staff had received a supervision session. The manager had delegated this role to senior care staff. One member of care staff said, "I had supervision recently from a senior carer. I got positive feedback and told that I was very good at my job. This meant a lot to me." A senior member of care staff who had worked at the service for several years told us, "[Recently appointed manager's name] has given me little extra jobs to do. I've got some responsibility, all the seniors have. I now do nutrition assessments and weights, and staff rotas and emergency evacuation plans for the residents. I've also been shown how to do supervision and I have two other staff to do [supervise]."

The registered nurses were having their skills expanded. We found that they had recently completed a training session provided by a pharmaceutical company on how to effectively and safely give a medicine through an infusion pump to a person living with a long term neurological condition.

We saw that some staff had been nominated as lead person for key topics and had advanced their knowledge to act as a resource for other staff. For example, a senior carer had taken on the role of dignity and dementia lead, a registered nurse had the lead for tissue viability and the manager for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

We observed that people's consent to care and treatment was sought by staff. For example, we saw that people had given their signed consent to have their photograph taken for identification purposes and for staff to administer their medicines. We observed that before a member of staff gave care to a person that they explained to them what they were going to do first and sought their agreement.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. Care plans demonstrated that staff had an understanding of the MCA and the requirement to ensure that people were able to consent to their care and treatment. The 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). Where a person's care and treatment was provided in a way that deprived them of their liberty, we saw an appropriate application for authorisation had been made to the local authority. However, another record that we looked at did not show that DoLS authorisation had been considered and the person was receiving care in a way that meant that they were under continuous supervision and control. We discussed this with the manager who confirmed that they would review their DoLS authorisation status and that of other people who lived at the service.

The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS. Staff told us how it applied to everyday care. One staff member said, "We should always treat the person as having capacity. And if they lack capacity, do the thing that benefits the client and act in their best interest."

People were provided with a well-balanced and nutritious diet. In addition, hot and cold drinks and snacks such as biscuits and cake were provided throughout the day. People told us there was always plenty to eat and drink and that the food was good. One person said, "The food's always been good but it's getting better all the time, the cook is pretty good." As regards choice they said, "They offer two [choices] but I'm happy with these and a salad if you want it so it's three really, that's not bad. If you want more you can always get it. You can always get a sandwich any time you want." Another person told us, "Both of them [choices] are good. Really good meat and fish. They come round with a tea or a coffee and some biscuits. They look after me."

People were given a choice of where they took their meals, some chose the dining room and others preferred to take their meals in their bedroom. People were supported to eat their meals without being disturbed. We noted that there was no television in the dining rooms and people were listening to gentle background classical music. People who had poor posture, were nursed in bed or had difficulty swallowing were supported by staff to sit in a position that helped to reduce their risk of choking. We observed that care staff regularly dropped in between meals on people who remained in their bedrooms through choice or for health reasons to offer to support them with a drinks or a snack.

We saw that the cook oversaw lunchtime and helped to serve the meals from a hot trolley. Where a person could not remember what they had ordered for lunch, staff showed people the meals available to help them make their choice.

We spoke with the cook who told us that there were aware of people's individual dietary needs. The cooks kept a record in the kitchen about which people were on special diets. In addition, the cook advised that they always asked for an update on any changes made to a person's diet when the dietician had been to visit people. They were aware of people's individual likes and dislikes and ensured that there were alternative choices available. When a person was at risk of losing weight staff liaised with their GP and they were prescribed nutritional drinks and puddings to supplement their diet. We saw in records that staff kept a note of what people had to eat and drink and that people were receiving drinks on a regular basis. The food charts gave an accurate record of the quantity of food a person had eaten. However the fluid charts were not always totalled so that daily intake could be easily monitored.

People were supported to maintain good health. We saw that people had access to healthcare services such as their dentist and chiropodist. However, although people were registered with a local GP practice, the

manager told us that it was difficult to get the GP to visit people in the service. The manager had requested a meeting with the GP to discuss the impact this had on people who lived at the service. We saw documented in one person's notes that their balance and coordination had deteriorated and this had impacted on their ability to swallow safely. Staff had referred the person to the occupational therapist to assess the person for a wheelchair that was appropriate to their needs.

One person told us how staff had helped them see the right healthcare professional when they were unwell and said, "If you're poorly they'll get in touch with the doctor. I went to hospital last week. They [nursing staff] organised that. The optician comes in and has a room here." We found that when a person who lived at the service was seen by a community or hospital out-patient health professional that there was clear written information about changes to their medicines or actions for staff to take. This ensured that the person received continuity of care.

Good

Is the service caring?

Our findings

People told us that they were looked after by kind, caring and compassionate staff and that they were well looked after. One person said, "The carers are very good. They look after me. We always have a laugh and a joke." They told us that the service was great and added, "I couldn't have looked after myself [at home]." We noted that when members of staff passed through the shared areas or entered a person's bedroom that they took time to acknowledge people; offer them a drink and sit and listen to what they had to say. For example, we observed a member of care staff go into one person's bedroom to offer them a drink. We saw the carer spoke for some time with the person about cars. They did this in a friendly, warm, non-patronising manner and it was clear that they knew the person's background and interests. We observed staff interacting with people and saw that people and staff had a good relationship and there was lots of friendly banter and laughter. One person who preferred to spend time reading in their bedroom and kept their bedroom door open told us, "They [staff] walk past and pop in and see if I am alright. Always someone walking past and they always look in."

We observed staff assist some people to the dining room for their lunch. People were supported to walk at their own pace and staff chatted with them in a friendly manner. We saw that one person sat alone at a table in the corridor to eat their lunch. We found that this was their choice as they liked to watch what was going on.

We saw that evidence based practices were in place to enable people to be orientated to their surroundings and find their way about the service. For example, people had their photograph and name on their bedroom door. Toilet and bathroom doors were painted yellow and had large print and pictorial signage on the doors. All service doors were painted white to match in with the corridor walls; this helped to reduce the risk of a person living with a dementia trying to gain access to a storeroom or another locked area. We found that the layout of the service provided people with lots of natural light. Natural light can be of therapeutic value to a person living with a dementia type illness as it helps to maintain a regular sleep pattern and slow down the onset of insomnia and daytime sleepiness.

To involve people who lived with dementia in conversation there were displays in the corridors of the music, fashion and news stories from the 1930s through to the 1960s. There was also a "memory lane" of what life used to be like in a nearby town where several people living in the service had grown up and settled with their family.

This dignified and caring approach by staff to people who lived in the service was not limited to nursing and care staff. We observed that the maintenance person, the cook and housekeepers also spent time with people and helped them with small tasks. All the staff we spoke with said they liked to spend time with people. It helped staff get to know people better. For example, the cook told us "I'll often stay behind and get involved." After lunch we observed the cook supporting a person living with memory problems to move through to the lounge. The person had communication difficulties yet they were doing "Elvis" impressions with the cook and we saw they were laughing together.

People were enabled to maintain contact with family and friends and people could receive visitors at any time. We found that family and friends were included in activities and the cook told us how they were working with the spouse of one person who lived at the service to arrange a coffee morning, as this family member enjoyed baking. One person had a relative visiting and we saw how staff engaged with the relative to discuss memories that were important to the person living at the service.

Senior staff told us that if a person was unable to make important decisions for themselves that they could have a lay advocate to speak out on their behalf. Lay advocacy services are independent of the service and local authority and can support people to make and communicate their wishes.

People had care plans tailored to meet their individual needs and they were encouraged to take part in reviews of their care plans. In addition, people were supported to make decisions about the care they received and when they received it. One person told us, "I can go to bed any time. I'd say you could stay in bed, but I like to be up in the morning." They added that they had a drink of water by their bed, but staff always brought them a cup of tea if they wanted it when they woke in the morning. Another person said, "I go to bed when I want and I think that goes for everybody. I don't think there are any rules."

Some people told us that they liked their appearance to be smart. We noted that some people had been assisted by care staff to colour coordinate their clothing and wear small items of personal jewellery. We noted that some ladies had their nails painted. The service had a hairdressing room and one person told us that a member of care staff cut people's hair. They proudly said, "He cuts your hair you know, for free."

Some people invited us to look at their bedroom. We saw that they had had a say in the decoration and furnishing of their bedroom. Most bedrooms were personalised with photographs and keepsakes that reflected their own taste and requirements. A member of staff told us "We try to put things they like in their rooms, ask family to bring in photos and things". We saw that one had their bedroom refurnished with units of their choice.

Staff exchanged information about a person's care needs and wellbeing at shift handover to maintain continuity of person centred care. We watched as staff coming on duty got involved in discussion about people's care needs with the registered nurse who had worked the morning shift. In addition, staff shared information through a diary of "things to do" and completed a daily handover record.

People were cared for by staff who responded to their individual care needs with dignity and respect. For example, at lunchtime one person became upset and agitated by another person sat at their dining table. Rather than let the situation escalate, a member of care staff immediately intervened and in a calm and gentle manner assisted the person away from the table. We saw they did this with appropriate touching, gently holding the person's arm and shoulder.

We saw that people's right to their privacy and personal space was respected. For example, we noted that staff always knocked on a person's bedroom door before entering and doors and curtains were closed when a person was receiving personal care. One person told us, "They always knock though I'm saying don't knock just walk in".

We observed that care and catering staff took a dignified approach at lunchtime. Before people were served their meal staff offered them wet wipes to freshen their hands and face. We found that when a person had their meals pureed that all food ingredients were presented separately and their meal looked appetising. We watched as a member of care staff assist a person living with dementia who was reluctant to eat their meal. They staff member sat down beside them, supported them to eat their meal at their own pace and treated

the person with dignity and respect throughout and acknowledged their achievement. However, we did observe a member of care staff call from the dining room door to people sat at the dining table to ask if they wanted a drink of juice with their meal rather than approach them at the table and ask quietly. We later shared this with the manager who said that they would address our observations with all staff. We found that people were supported to celebrate special occasions. For example, the cook supported people to celebrate their birthday by making them a cake.

Good

Is the service responsive?

Our findings

Care plans were person-centred and people and their relatives were involved in planning their care and took part in regular reviews. One person told us, "They'll come, the nurse and sit and work out what I need." Information in care plans described people's lives and histories, their preferred foods and activities. There were detailed descriptions of people's communication needs and how to enable people to make choices. We saw where there were changes to a person's wellbeing that this was recorded in their care file. For example, one person had developed a pressure sore and we saw evidence that this had been regularly monitored. We saw that the recently appointed manager had reviewed people's care plans and had ensured that people's needs were being met. For example, in one care plan, someone had been through a period of weight loss and we saw that the manager had ensured that appropriate referrals were made to the person's GP. Plans to support people with their mobility and issues such as personal hygiene were also detailed. A "This Is Me" document was kept separately describing people's life histories and likes and dislikes which could accompany people if they were admitted to hospital. A registered nurse told us that they also sent a photocopy of the person's medicine administration record with them.

We looked at the care file of a person who received care on a one to one basis and saw that notes were kept throughout the day so that the provider could be assured of the level of care that the person had received. We observed this person and the member of care staff who was allocated to look after them. We saw that the member of staff was attentive to the person's needs, but also gave them their privacy and peace and quiet when the needed it and watched from a safe distance.

We observed a group activity being supported by staff, and most people in a communal sitting area were engaged in colouring in drawing books. However, one person told us that they missed using their personal computer. We discussed this with the manager, who informed us that they were currently liaising with the person's family to have their computer brought in to them."

The manager and provider interviewed for an activities coordinator on the day of our inspection. The full time activity coordinator had been in post since January 2016. However, they had recently been appointed to the role of administrator. The staff member was currently dividing their time between both roles until a new activity coordinator was appointed.

The activity coordinator informed us that entertainment was provided from visiting singers and a pantomime. Once every couple of weeks people were supported to join in exercise classes led by an external fitness instructor. These were intended for people of all physical abilities and helped to improve a person's coordination and balance. We found that people enjoyed these organised events. One staff member told us, "You see people who are usually very quiet joining in the singing. It takes them back."

The activity coordinator said that they were unable to provide group trips out, as the service did not have its own transport. However, some people were able to use the rural bus service and staff would take them to the pub for a meal. One person told us that they were going to the pub for tea with one of the housekeepers that evening.

The service kept guinea pigs and rabbits and people were supported to look after them. Staff told us that people found fondling the rabbits therapeutic. We saw photographs of this activity on display. One person kept chickens and ducks and was responsible for looking after numerous wild bird feeders in the grounds.

We looked at the "resident's activity participation record" and found that the recorded activities were not meaningful or stimulating and did not reflect people's individual interests and pastimes. For example, reading, watching television, chatting, visits from family and listening to music." Some people we spoke with were happy spending their time this way. One person who preferred to remain in their bedroom said, "I sit and listen to my music and watch TV, read a bit. I'm not bored; it's all I'd do at home". Whereas other people wanted to do more with their time, such as go for walks. One person said, "[name of staff member] used to take me for a walk. That has stopped now. I would like to get out more."

Although, care plans described a person's life history and preferred activities we saw that this was not always evident in practice. Some steps had been taken to introduce activities and pastimes to people, but these were inconsistent, were not person centred and did not respond to individual choice and need. There was a risk that people would not achieve their optimum level of independence, and would become disempowered and socially isolated through the lack of meaningful activities.

Although the provider displayed the complaints procedure in the entrance foyer, it was printed in such a way that it would be very difficult to anyone coming in to the service to read. However we looked at the complaints records and we saw that all complaints were recorded and responded to, including issues that people had shared on an informal verbal basis. This assured us that if people had concerns or complaints about their care and treatment, they would be responded to. People who lived at the service told us that they had no need to complain that they could always talk with staff or the manager. One person said, "If there's ever anything wrong you've only got to tell them in the office and they'll sort it." The staff we spoke with were aware of the complaints policy and could explain the steps they would take if a person or their relative shared their concerns with them.

Following our inspection the provider informed us in writing that, all of the people who lived at Laughton Croft were provided with a copy of the service users' guide on admission. The service users' guide contained easy read guidance on how to raise concerns and make complaints about the service."

Requires Improvement

Is the service well-led?

Our findings

At our inspection in February 2015 we identified that systems and processes were not operated effectively to assess, monitor and improve the quality and safety of the service. This was in breach of Regulation 10 of the Health and Social Care Act2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After our inspection the provider wrote to us and told us what they had done to meet the legal requirements. At this inspection we found that actions had been taken to meet their legal requirements and the provider was no longer in breach of the regulation.

We looked at the provider's audit processes. The new manager had struggled on their arrival to establish which audit systems were already in place and shared with us that they were, "starting from scratch." We spoke with a director of the provider company who told us that they were planning to introduce a company-wide governance however this work was still at planning stage. We saw that there were audit systems in place however the planned monthly audits had not been undertaken since July 2016. Although there was a wide range of audit tools, including the monitoring of the cleanliness of shower heads and checking pressure relieving mattresses, they did not lead to clear action plans which had been followed through. For example, a nutritional audit undertaken identified a number of areas which were not properly addressed, and an action plan had been written which had been ticked as done but it was not clear what action had been taken and when.

Staff told us that the manager was approachable, supportive and dependable. One member of staff said, "[Manager's name] is marvellous, you can talk to her and she does listen and she does something about it." Another staff member told us, "[Manager's name] is approachable in a management role, not as a friend, is professional and if she says she'll do something she does it." Another staff member said, "[Manager' name] very, very open to our suggestions. Very approachable and listening, she sees what needs to be done."

We saw that a programme for quarterly "relatives and residents" meetings was on display in the foyer. However the people we spoke with said that they were not aware of these meetings. One person told us," I can't think of any meetings but you can give your view anytime you like." People told us that they knew who the manager was and that they were approachable. One person said, "She's a happy, nice person. She'll always come round and talk to you." The manager told us that although they wanted to be a visible manager and available to people and staff the location of their office did not make it easy for people who lived at the service and staff to drop-in and speak with them. This was because the manager's office was situated at the entrance to the service and people were unable to access it because there was a digital keypad locked door between them and the rest of the service. If the keypad door was left unlocked there was a risk people could wander out of the service unaccompanied. The manager said that they were looking for an alternative room with the main body of the service.

Members of staff told us that regular staff meetings were held and they were expected to attend four a year. We found that these meetings were held at the shift handover time to enable staff to attend.

We spoke with the recently appointed manager who was enthusiastic about the potential for the service. They were open and honest with us about which areas would need improvement and described their ambitions to make further improvements to the service. They described how they did a 'walk around' every morning with the maintenance person to check the premises and also used the opportunity to talk with staff. The manager described an ethos of empowerment for the staff and told us that they were looking at the competencies of senior staff, such as registered nurses and senior care staff, so that they could take on more professional development opportunities relevant to their role. For example, there were no boundaries between the roles of care staff and senior care staff.

Staff felt positive about the new manager. One staff member told us, 'I could sit and listen for hours, the stuff [the manager] knows about dementia is unbelievable'. A registered nurse spoke highly of the impact the recently appointed manager had made so far and said, "It's better than before. [The manager] is making changes. She has given us our work back. We know what we are doing with everything. Medications, nobody is now missing medications. I know what is happening." This was said in response to the previous manager who had taken responsibility for medicine management away from the registered nurses and due to poor stock control people often went without the medicines. The housekeeping staff spoke about the difficulty of having a big turnover of managers in the last 18 months. One said, "We are ok at the moment. It is starting to pick up again. We've had so many managers. [The manager] is stronger. More of a leader. I would be comfortable to go to her."

All of the provider's policies and procedures had been recently reviewed. This covered a wide and detailed range of information including issues such as equality, diversity and human right, the significance of supporting older people to maintain friendships, and practical information around the management of continence.

The service was a registered member of the Lincolnshire Care Association (LinCA), which provided opportunities for training, networking and sharing good practice for staff, with the overall outcome of improved health and wellbeing of the people who lived in the service. In addition, a director of the provider company was also a director at LinCA.

We observe that all staff worked well together as a team and morale was good. One member of staff said, "We all know our roles but we'll help each other, you know the job needs doing. We're a good team." Another member of staff told us, "The permanent staff are now happier [since the new manager started.]"