Superior Care Homes Ltd

The Laurels Residential Home

Inspection report

The Laurels, Bull Lane
South Kirkby
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Tel: 01977640721

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
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

The inspection of the Laurels Residential Home took place on 27 and 28 March 2017 and was unannounced on the first day. People and staff living and working at the home refer to it as 'The Laurels'. At the previous inspection in September 2016 we found the home to have made some improvements and was rated as 'requires improvement' overall. However, due to concerns in the safe domain this was rated inadequate and the home remained in special measures. There were four breaches of Health and Social Care Act regulations in dignity and respect, safe care and treatment, good governance and staffing. During this inspection we checked to see if further improvements had been made and that others had been sustained.

The Laurels provides accommodation and personal care for up to 28 people. Respite care is also provided. The home is over two floors with bedrooms on each floor. There is a secure garden easily accessible by the conservatory with a portable ramp to assist people using wheelchairs. On the days we inspected there were 19 people living in the home, four of whom were new admissions since the previous inspection. No one was currently sharing a room as all single rooms were being utilised first.

There was a registered manager in post on the days of the inspection. 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.

We found people were happy and settled. They told us they felt safe and supported by the staff team who they had confidence in. We saw any safeguarding concerns had been reported appropriately and the registered manager was pro-active in supporting people where any issues were identified.

Risk assessments were more person-centred and focused on individual need. Staff displayed good techniques in relation to moving and handling practice which had improved greatly since the last inspection. This was supported by more robust documentation providing detailed guidance for staff to follow.

Staffing levels remained the same as before but there was evidence of clear leadership which meant staff understood their roles and liaised with each other more often. This meant people's needs were responded to in a timely manner. Staff also displayed greater awareness of risk reduction measures such as falls prevention and conflict management, reinforcing positive interventions for people and reducing the risk of harm.

There were no issues with medication on this inspection and we found administration, storage and records all in line with stock levels and people's requirements.

Staff had received regular one to one supervision as well as observations of their practice. This gave them the opportunity to develop their confidence and knowledge, and identify any areas they needed further

training in. We saw all training was up to date and plans in place for regular updates.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Nutritional and hydration needs were met pro-actively with staff offering regular drinks and snacks to people in addition to more organised mealtime experiences for people. People who were on bed rest had regular checks and appropriate levels of pressure care relief.

Staff displayed warm and friendly relationships with people, and it was obvious the needs of people living in the home were their first priority. This was a significant culture shift from the previous inspection where people had been ignored. There were many examples of positive interaction and it was highly evident staff knew people very well.

Although formal care plan reviews seemed limited, discussions with relatives and other visitors showed the registered manager was very knowledgeable about each person's needs, which was mirrored in the conversations with staff. Staff were engaged and relaxed in their approach and this helped promote a calm and pleasant atmosphere.

Care records were relevant and reflected the needs of people. They were regularly reviewed and provided guidance to staff about how best to support people in the home. They were used frequently by staff to ensure information was current and any changes were made known.

Complaints were limited but the investigation and responses were handed well, and compliments were displayed in the home.

The registered manager had continued the transformation of the home through focusing on the small details such as people's comfort, as much as the larger issues. This showed good foresight and skill. The quality assurance systems were more robust and aided the improvements in the home rather than being a task in themselves. The tools were appropriate and effective in highlighting key areas to monitor and provided sound evidence of where progress had been made. It was very clear from this inspection the registered manager and staff had worked incredibly hard to improve standards of care and drive up quality for people living in The Laurels.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

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 safe.

The provider had taken appropriate action and was now meeting legal requirements in this area. Whilst improvement had been made we have not rated this key question as 'Good'; this would require a longer track record of sustained improvement.

People were safe as staff had a sound understanding of how to identify and report any concerns.

Risk assessments were detailed and based on individual need with clear guidance for staff.

Medicines were administered, recorded and stored in line with guidelines and the service had an appropriate level of staffing to meet people's needs in a timely manner

Is the service effective?

Good

The service was effective.

Staff were supported with regular supervision and training, and all had received a comprehensive induction.

The service was acting in accordance with the requirements of the Mental Capacity Act 2005 and people's consent was sought wherever possible.

People were supported with their nutritional and hydration needs and had access to health and social care support as required.

Is the service caring?

Good

The service was caring.

Staff were consistently patient, caring and kind and engaged with people whilst respecting their right for privacy.

We saw good examples of dignity being respected.

People were encouraged to make as many decisions as possible themselves.

Is the service responsive?

Good

The service was responsive.

People were supported to undertake activities of their own choosing.

Care records were person-centred and detailed people's needs.

Complaints were handled in a timely and responsive manner to the satisfaction of the person raising the concern.

Is the service well-led?

Requires Improvement

The service was well led.

The provider had taken appropriate action and was now meeting legal requirements in this area. Whilst improvement had been made we have not rated this key question as 'Good'; this would require a longer track record of sustained improvement.

People appeared happy and contented and staff expressed how much they liked working at The Laurels as they felt supported and valued.

The service had a pro-active registered manager who constantly sought to improve the service.

Auditing systems measured progress, consistency and quality which all showed how this was achieved.

The Laurels Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 27 and 28 March 2017 and was unannounced on the first day. The inspection team consisted of one adult social care inspector.

We had not requested a Provider Information Return (PIR) before this inspection as we were visiting the home to ascertain what progress had been made. 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 checked information held by the local authority safeguarding and commissioning teams in addition to other partner agencies and intelligence received by the Care Quality Commission.

We spoke with seven people using the service and four of their relatives. In addition we spoke with five staff including two care workers, one senior care worker, the activity co-ordinator and the registered manager.

We looked at five care records including risk assessments, three staff records including all training records, minutes of resident and staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in September 2016 we found breaches of regulations relating to safe care and treatment and staffing. We found the provider was not ensuring safe management of medicines, had appropriate risk assessments in place, moving and handling procedures were unsafe and there were not enough staff to meet people's needs. We rated this domain inadequate. At this inspection we found the provider had taken action and was now meeting legal requirements regulations. Although we saw improvement had been made, we have not rated this key question as 'good'; to improve the rating to 'good' would require a longer term track record of consistent good practice.

At the last inspection we were concerned about poor moving and handling practice. This time we observed much safer and more confident procedures. Staff explained to people what was about to happen and then gave clear directions to support people to stand independently or with a zimmer frame. Where the hoist was used people were supported with the appropriate sling and staff were confident in the procedure, reassuring people the whole time. Brakes were applied to wheelchairs before people sat down ensuring a much safer transfer and footplates were used on every transfer we observed.

One person safely transferred into a wheelchair had left sided weakness and we heard a senior member of staff highlight to the care worker the person's foot had slid forward on the footplate. The carer worker immediately moved it into a safer position as the person was unaware this had happened. On another occasion one person was transferring from a wheelchair and advised to keep the frame close to them and feel for the arm of the chair before sitting down. Staff also stressed to people they needed to get their balance before moving with their zimmer frame. Care staff directed people who would not appreciate the risks to themselves. This showed a greater awareness of the risks and confidence in supporting people to move and transfer and attention to the smaller details which all helped promote a better quality of life and reduce the likelihood of harm for people in the home.

Moving and handling assessments were reviewed monthly and we found the ones we checked reflected people's actual need. They considered people's weight, pain levels, any other physical concerns and behavioural responses. People who needed them all had their own slings and staff knew this was to reduce the risk of infection. Falls assessments were equally reflective of need and identified factors which may increase the likelihood of falls such as unsteady gait, specific medication or being restless at times. Risk reduction measures were in place and staff demonstrated a sound knowledge of these in action through the practice we observed. Accidents and incidents had been monitored and analysed on a monthly basis showing any actions were taken where necessary such as referrals to external agencies for further mobility equipment.

During the previous inspection we found a lack of risk assessments in place for use of specific equipment such as shower seat or the bath hoist. This time we found these had been written and gave clear guidelines to staff as to how best support people. Some of these were still a little generic in nature and we discussed with the registered manager the importance of ensuring people's specific conditions were considered. All equipment had been checked as required under the Lifting Operations and Lifting Equipment Regulations

2008 and everything was in working order. The registered provider responded promptly if any issues occurred.

We saw people had personal emergency evacuation plans (PEEPs) which assisted staff in the event of a serious incident such as a fire to evacuate people quickly and safely. This included information about a person's mobility, whether they needed any specific equipment, cognitive abilities, sensory needs and medication which may affect their responses. These were available in a bag which was easily accessible containing wrist bands and other key information to assist the emergency services. The home conducted monthly fire drills and weekly fire alarm tests to ensure all staff knew what to do in an emergency, and staff were able to relay the procedures to us.

People told us they felt safe. One person said "Yes, I feel safe as I know the staff well. They are the same people." One relative told us "I feel my relative is safe living here. There are enough staff as we've never had to press the bell twice and we visit often." They continued to tell us how reassured they were that a pressure mat was in place to alert staff if their relation tried to get out of bed unaided.

Staff we spoke with had a good understanding of what may constitute a safeguarding concern. One staff member told us "Abuse may be physical, sexual, institutional, financial or neglect." They knew how to report such concerns and what to do if they felt the matter had not been taken seriously enough. They told us they had worked in the home at the inspection which had identified the serious issues and felt it had improved beyond all recognition. Another staff member said "I know I can intervene if people are putting themselves at risk. I always try to make sure people who don't get on are kept apart to avoid the risk of incidents. I have never seen anything here which has concerned me." This staff member gave some good examples of techniques to defuse conflict showing they understood how to manage more challenging behaviour. All concerns of this nature had been reported appropriately and investigations conducted in line with expectations.

We found much the premises had been improved and all corrective work found at the last inspection had been completed. The home had been redecorated throughout and all repairs had been actioned. The odours had been reduced and floors were in the process of being replaced where there were issues. Since the last inspection, sensory mats had been purchased to further minimise the risk of falls so staff could respond to people quicker. Key codes had been placed on all doors to the downstairs to prevent people from accessing the stairs without support. The lift had also been fitted with sensors which were down the side of the doors and prevented the doors shutting if there was an obstruction. These safety measures all highlighted the focus in minimising risk to people in the home.

Recruitment checks for new staff had continued as during the previous inspection with full references and Disclosure and Barring Checks taking place before any staff member worked. Interview questions were detailed and identity checks were made. All new staff received an induction which covered their role, policies, the principles of person-centred care and medication among other areas. The checklist was signed by the employee and the registered manager.

The registered manager advised us dependency levels of people in the home had lessened which meant staff were able to respond to call bells quicker and generally had more time to spend with people. People who chose to remain in their rooms all had their call bells within easy reach and we observed staff popping in to see people at regular intervals to check they were alright. A visiting health professional told us "The home is very organised and there are usually staff available to support when we visit." We found staff response times were much improved from the previous inspection, partly due to people's lower levels of need but also because staff were clear in their roles and communicated much better between themselves.

Staff did not mention any concerns regarding staffing numbers and they felt all staff pulled together and supported to cover shifts if anyone was sick. Each staff member had their photograph on a display board which helped people identify who was working.

We saw evidence of dependency tools used for each person which assessed their mobility, personal care needs, communication ability, nutritional requirements and skin integrity amongst other areas. These were reviewed on a monthly basis to ensure staffing levels were appropriate for people's needs. We met some of the staff we had seen on the previous inspection and a visiting health professional confirmed the staff team was stable as "I tend to see the same faces."

People's medication records were up to date and information in their care records corresponded with the medicine administration record (MAR). We saw one person had recently been prescribed some medication to manage some more complex behaviours and the care record reflected this with guidelines for staff as to how best support this person.

We observed medication being administered at lunch time and found the correct process was followed. We found none of the issues we had observed at the previous inspection which showed the registered manager had taken the concerns very seriously and re-trained staff. People were asked before they received their medication if they were happy to take it at that particular point, and those who were on PRN (as required) medication such as painkillers were asked if they needed any and these were duly given.

The medication room had been fitted with an extractor fan and better ventilation than we saw during the previous inspection. This had helped to regulate the room temperatures which were monitored closely. We checked the fridge temperature and saw this had been regularly monitored. There were records detailing all people in the home, their GP and when they had last had a medication review. These had all been done within the last year. There was also a signature list of all staff who were trained to administer medication which meant records could be verified if errors came to light.

All stock was in date and ordered very neatly. People had individual medicine profiles which included their photograph, GP and any allergies. We looked at three people's MAR and all stock levels tallied with the records. Each day a medication audit occurred which checked the MARs and the controlled drugs stock including whether records showed two staff had signed for them. We found no issues with storage and saw boxes and creams were dated when opened ensuring they were not past their expiry date. Staff's competency in regards to medication administration had been assessed robustly through observation and knowledge checks.

Staff had access to personal protective equipment and we saw this in use during the day.

Good

Is the service effective?

Our findings

One person told us "Yes, I get enough to eat. I am always asked if I want seconds. There is a good range of food." Another person said "Yes, I got my choice of breakfast which was toast and tinned tomatoes." One relative told us "My relation has recently been unwell but staff have been very encouraging trying to get them to eat and drink. They've offered smaller amounts so my relation doesn't get overwhelmed."

People were offered a choice of drinks throughout the day and their preferences checked, such as if they wanted sugar when they were offered drinks so no assumptions were made. Where people were likely to forget to drink, we observed care staff sitting with people encouraging them to drink. We found people's food and drink preferences noted in their care records which assisted staff when supporting people to make choices.

We observed lunch and tea times and found the general experience for people was much better than during the previous inspection as it was more organised. Each staff member was assigned a particular role and they ensured this was carried out before assisting with other tasks. We found some people had been seated in the dining area for some time before food was delivered but these were people who were independently mobile. One member of care staff was responsible for plating up the food, after checking with the person their choice, but they also had a checklist indicating the consistency of food and any other special dietary requirements.

Most people chose to eat in the dining room and people who needed support to eat were offered this promptly and discreetly, whether through assistance of staff or more specialist equipment. One person was struggling to put food on their fork and a staff member bent down to ask if they wished to have some assistance. Condiments and serviettes were available on tables for people to use along with cutlery which had not been the case at the previous inspection. One person noted the menus out on the table were for the previous week and when this was pointed out a staff member was very apologetic and offered to get the person an alternative meal. People who chose to remain in their rooms also had their meals in a timely manner and where they had changed their mind, alternatives were offered. People were encouraged to eat more where they had been reluctant and others were offered more if they had finished their first course. Everyone was offered a choice of dessert.

People who were deemed at nutritional risk had food and fluid charts in place. These were detailed with specific dietary intake recorded such as the quantity of cereal or liquid consumed. Staff knew if people were at risk of malnutrition they were to be offered fortified food and snacks such as milkshakes, and also were able to tell us who needed extra oversight during mealtimes due to their needs. We noted the food and fluid chart totals were not always tallied which meant staff were unable to see easily if a person had reached their required intake for that day. We spoke with the registered manager about this and they agreed to remind staff of the importance of this. The home had a nutritional tool which included recording people's malnutrition universal screening tool (MUST) scores to monitor for any significant weight loss and identify other risk factors, and we saw referrals to outside agencies where necessary.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.
Staff were able to tell us the five principles of the MCA when we asked. One staff member said "We never assume someone lacks capacity or can't make a decision." They were also aware of who had a DoLS in place and what this meant. They knew they had the authority to try and stop someone leaving the home which they would do by use of distraction techniques or by going for a short walk if this was a more appropriate decision.

Where people did not have the capacity to make a decision such as taking medication or the use of a sensor mat we saw capacity assessments completed which followed the two stage test as required under the MCA. The assessments were decision specific and detailed the reason for whether the person had capacity or not. This also applied to the decisions for DoLS. In one assessment we saw "[Name] does not have the capacity to choose to live here. They said they did not live here and were going home. They did not know the name of the home." The DoLS application for this person was progressing with the local authority.

Signage throughout the home was clear supporting people to access the toilets and bathrooms as needed. People had their photographs and names on their doors.

In people's care records there was evidence people had received regular support with visits to the dentist, GP, optician and other professionals. Relatives we spoke with confirmed the home rang for support as soon as it was needed. Outcomes of appointments were recorded in care notes and, for example if new glasses had been prescribed, when they were to be used which helped staff check if the person was wearing the correct pair. We noted staff were very attentive to such details and one member of care staff offered to locate a pair of glasses which had been misplaced. They duly brought them to the person and offered to clean them. The chiropodist visited the home on the second day of the inspection. We saw evidence of people's forthcoming appointments with health and social care professionals, enabling staff to arrange appropriate support and cover so people could attend.

The registered manager had been involved in a recent discussion with health professionals about some more complex behaviour being displayed in the home by one person and the potential use of medication to control this. They had felt uncomfortable with this option and so had sought others' opinions to ensure they had considered all possible avenues of supporting this person before medication was used. They had implemented close monitoring of this person and requested regular reviews. The registered manager also discussed with us other people who were waiting input from external services and what measures they had instigated in the interim to help people. They told us three different people who use the service had all been able to increase their levels of independent mobility by care staff building their confidence and abilities following advice from other health professionals.

People had their pressure care needs met through the use of necessary equipment, regular re-positioning if they were in bed and contact with the district nursing service if any red skin was identified. Body maps were

kept in people's rooms with records of topical medication applications. A visiting health professional said "The staff will do what they are asked to do if someone gets a sore area and they do know people well." One staff member told us "I know how important it is to keep people moving as this reduces the chance of pressure areas developing." They explained all the risk reduction measures in place.

Staff had received training in all key areas such as moving and handling which involved both theory and practice, fire safety, health and safety, infection control, nutrition and food, insight into supporting people living with dementia, safeguarding and mental capacity.

Staff had also received supervision which recorded agreed actions. These sessions included discussions around care staff's role, the importance of focusing on the individual when providing care, ensuring independence was promoted and to follow the direction of senior care staff when instructed. In other notes we saw evidence of discussions around the prevention of falls, how to support people with more complex behaviour and the consideration of a care plan to see it reflected the needs of that person. One staff member said "I am always checked to make sure I have completed the actions we agreed which is good as it keeps me developing." Notes were signed and dated by the employee and the registered manager.

Staff also told us the registered manager had observed them undertaking key personal care tasks to ensure they were competent in their role. Feedback was given after each observation and the staff member allowed to reflect on their own levels of confidence. This level of support for staff showed the registered manager had a sound understanding of what care staff were required to do and how to ensure they were confident in performing in their roles.

We also saw evidence of appraisals which focused on empowering staff, staff's achievements and where further training or development was needed. Comments included "I feel my manager has helped me become more confident and given me a lot of knowledge."

Good

Is the service caring?

Our findings

At our last inspection in September 2016 we found a breach of regulation relating to dignity and respect. We found staff did not always acknowledge people and spoke about them rather than to them. At this inspection we found the provider had taken action and was now meeting legal requirements regulations.

One person said "Staff are very good. I can't fault them." Another person said "Staff always help me." One relative told us "The care is good. The staff are very good with my relation."

Interactions with people were very positive and enabling. One person was asked by a member of care staff if they would like a cup of coffee. The person was walking into a lounge at this time and the member of care staff took hold of their hand guided them to a seat after asking which seat they preferred. The member of care staff was very patient as the person took some time to sit down but at no point did they hurry them or make to walk away. Another person who struggled to communicate verbally was listened to at length by a member of care staff and reassured by them. We heard a conversation between another member of care staff and a person in the home which reflected their trusting relationship; the person had said "I'm 86 you know" and the member of care staff replied "Well, you don't look a day over 90!" which made the person laugh.

On another occasion one person who frequently chose to walk between the lounges was in the corridor but a member of care staff spotted they had left their drink so picked this up and brought it to them enticing them to drink it. Another person was offered a new cup of tea as their previous one had gone cold as they had gone to have a shave. A further person was supported to access the bathroom and the member of care staff took their time, holding their hand and being very patient with them. This showed people were treated in high regard and staff were aware of the importance of regular hydration.

People looked clean, were well dressed and wore appropriate footwear. On the second day of the inspection we noted people were wearing different clothes which showed the home was ensuring people were well cared for. We heard the gentlemen in the home being offered shaves and duly supported to undertake this, and later in the day people were offered a bath or shower. We saw people were always acknowledged directly, even if just being passed in the corridor by staff. This meant the home had worked hard to promote people's dignity and was an improvement from the previous inspection.

During the lunchtime meal one person got up as they wished to use the toilet and staff were quick to respond and offer support in a discreet and sympathetic manner. This happened a further time but again staff responded sensitively and patiently despite the pressure of mealtimes. Another person was ill when they stood up and staff responded quickly and with full sensitivity as the person became upset. This showed the principles of person-centred care had become integral to care delivery at the home.

There was a display on the wall in the corridor of a dignity tree which defined what dignity was and had leaves attached with different comments as to how staff could display this in their everyday interactions. It was evident through our observations these comments had become embedded in practice in the home as

the attention to small details was as obvious as the more routine tasks.

We asked staff how they supported a person with their privacy and dignity. One staff member said "I always knock on people's doors before going in, draw their curtains and cover them with a towel. I encourage them to make their own choices about a bath or shower, and try to persuade them if they refuse. I ask them if they would like bubbles in their bath and always communicate at their level by sitting next to them rather than standing over them." We observed the staff member throughout the day communicating with people in this manner which showed they appreciated the importance of such methods.

We asked staff if people were involved in their care plan reviews. One staff member said "For people who are able, we discuss their care plans with them and they sign it. We check everything monthly and if there are any changes make these." They also told us people had been involved in choices about the paint during the recent re-decorating of the home. Another staff member said "We write down what people think and how they like their needs to be met. We involve them as much as possible."

Each staff member was assigned a particular role to ensure they were the expert in this area such as dignity and respect, palliative care and infection control. Staff also had keyworker responsibilities which included ensuring people had regular nail care, they had all the toiletries and clothes they needed and their rooms were kept tidy and organised. One staff member told us "If a person needs help writing a letter I will do this for them, or I can help read letters to people."

People's preferences as to the gender of care staff were obtained at their initial assessment and recorded in their care records. The home had a mix of male and female care staff which meant it could meet people's preferences as far as possible. We asked staff how spiritual or cultural needs were addressed. One staff member said "One person used to go to church but no one does at present." They said there were no current church services held in the home as no one had requested these.

We saw a local advocacy service advertised in the foyer of the home which meant people could access external support if they needed it.

Good

Is the service responsive?

Our findings

One person spoke with staff about their recent trip to the local pub where they had enjoyed a shandy. A number of different staff throughout the day spoke with this person about this independently so it was obvious staff had a good knowledge about this person's activities. Further conversations with people included football, rugby league, allotments and the forthcoming Grand National. These all helped stimulate people's memories and interest. One relative we spoke with told us about the exercise class which had been held the previous week and all the craft activities the home did.

We heard people being asked their choice of watching the TV or listening to music while sitting in the lounge areas. The home was very lively at different parts of the day. On the first day we heard discussions about dancing, about people's own experiences and how much they had enjoyed these activities. On the second day people played bingo and scrabble. People's interests and hobbies were noted in their care records, and we saw staff try to engage with people wherever possible about these. Activities records in people's file showed a range of events such as a sing-a-long, attendance at a coffee morning, playing games and watching films.

There was an activity board with posters advertising forthcoming events such as the Easter parade and photographs of a recent vintage tea party. A display of Easter cards prepared by people in the home brightened up the hallway along with some decorated pots all ready for Easter eggs. We observed one person being supported by the activity co-ordinator making such a card. The person had limited verbal communication skills but was smiling as their hand was being stroked by a feather and we saw some very positive one to one interaction. There was also a silver tree decorated with painted Easter eggs which had become a discussion point during the day as people discussed the colours and the decorations.

We looked at care records and found they contained a photograph, next of kin details, and other pertinent medical information. People's life histories were included which helped staff in getting to know people and the important people in their lives. Care records also contained an overview of people's physical and social needs to identify key support requirements. Where people had particular health conditions, information leaflets were in their care files to provide information and advice to staff as to how these conditions may impact on the individual. Care plans included signs to look for such as when supporting a person with diabetes and what action to take if the person demonstrated these. The care plans also linked emphasising the importance of regular foot care and eye tests showing the registered manager had appreciated the holistic impact of such a condition.

Each person had a care plan which focused on individual needs for mobility, nutrition and hydration, personal hygiene, communication, medication, pressure care, behavioural support and other specific needs pertinent to that individual. These care plans included an initial assessment, a risk assessment and evaluation sheet. In one record it was noted '[Name] will ensure all areas are thoroughly washed by prompts from staff but requires one carer to help to dry. Staff to check for any red areas and report any concerns." In a further record it said '[Name] is able to make their own choices about their clothes. Staff will choose from two options, offer and ask [name] if they would prefer to wear anything else.' It continued with the person's

usual combinations of clothing to assist staff when offering the choice of outfit. We also saw evidence of people's particular routines for showering or bathing.

Behavioural support plans offered staff clear guidance when helping people who may not have wanted assistance. It stated "Staff should explain all personal hygiene needs and present in a compassionate manner. [Name] will respond if they are reassured and explanations given." It continued with information about how the person may respond if still resistant and advised staff of what action to take in such circumstances. There was good evidence in this care record that such distraction or delay techniques worked and defused the tension as there were several incident logs of more difficult behaviour which staff had had to manage. Staff demonstrated in-depth understanding of people's care plans through discussions we had with them which showed they were a working document.

Daily notes were kept for each person with a basic overview of all the care support they had received such as personal care, mobility, medication, activities and any behavioural support. If there had been issues these were noted and also highlighted on the handover sheet for staff on the next shift to note and observe.

We saw full audits of selective care records had taken place monthly ensuring they reflected people's needs in addition to the monthly evaluations of the care plans. Any issues were noted and followed up in staff meetings or in supervision. We randomly checked some care plans to see if these actions had been completed and found they were.

Staff told us they had not been involved in any complaints but were able to explain the procedure. One staff member said "I would write down the issue and tell a senior or deputy. I would like to know if the matter had been dealt with so would ask." We checked the complaints file and found responses were timely, apologies offered and investigations had been completed. Only two complaints had been received since the last inspection, both of which were resolved to the satisfaction of the complainant and had involved working with other professionals.

The home had a feedback box where anyone could put in suggestions to improve the running of the home and there was also a display of compliment cards in the foyer, although not all of these were dated. However, comments were very positive and spoke highly of the home and its staff. The pharmacist had noted following their audit of the home's medication, "The home should be proud of what it has achieved so far."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in September 2016 we found a breach of regulations relating to good governance. We found the risks were not always monitored and mitigated by the provider effectively enough. We rated this domain requires improvement. At this inspection we found the provider had taken action and was now meeting legal requirements regulations. Although we saw improvement had been made, we have not rated this key questions as 'good'; to improve the rating to 'good' would require a longer term track record of consistent good practice.

One person told us how much they liked living at the home as they had recently moved from another home. They told us "I am not going to find any fault. I like the people and the garden is lovely." One relative said "The manager is fine. They ring us if there is anything we need to know. Anything at all, they will let us know." Another relative we spoke with after the inspection was full of praises for the home following the recent admission of their relation. They told us "I have seen a distinct improvement in [name] since they came here. Their health and wellbeing have improved so much. I am delighted with the Laurels, and the manager is great as they visit and speak to people. This home has to be commended."

There was a registered manager in post and they were available on both days of the inspection.

People had been asked for their views on living in the home in September 2016 and actions stemming from this were completed such as a suggestions box in the reception area for people to select activities and other improvements to the home from. It was noted were staff were praised due to the 100% good rating by people about staff's conduct. The overall satisfaction rating was 94%. There was a corresponding relatives' and visitors' survey, professionals' survey and staff which reflected the same findings.

We saw a poster advertising the forthcoming resident and relatives' meeting for 7 April 2017. Previous minutes from September 2016 discussed the previous inspection findings and what actions had taken place to address the concerns and included feedback from relatives. Although this was a large gap, we were not concerned as it was evident there was enough general discussion to ensure people's views were obtained and acted upon. The registered manager was very visible and people spoke to him each time they saw him. One relative we spoke with told us all about the different events organised at the home. They said lots of people were local and so the home was a significant part of the community, and families visited on an almost daily basis.

There was evidence of positive directional leadership in the home, by both the registered manager and senior care staff. We heard one senior care staff ask a member of care staff to support one person with their mobility and they duly responded. A member of care staff advised the senior care staff they were taking out some rubbish thus ensuring the location of staff was noted. This level of communication was much improved from the last inspection. Staff also told us about handovers which occurred at the end of each shift, and was both verbal and written. This ensured information could not be missed.

Staff told us they felt comfortable raising any concerns with the registered manager and that if they did,

these would be acted upon. One staff member said "Things are much better now. I enjoy coming to work and I know things get resolved. I have more in-depth training and am much more relaxed as I know what I am doing. We always go by what people want to do rather than us telling them." Another staff member told us "I love my job. We have a very good manager. They are completely different and the atmosphere has changed for the better. People are much more at ease and it feels better to come to work. I think this home is going from strength to strength." We also asked staff if they saw the registered provider and all told us they had. We also asked staff what they felt the values of the home were and one told us "To be a good care team. Everyone gets on well and we all talk to families and visitors."

We discussed with staff how they knew they were doing a good job. One staff member said "Through my training, supervision and appraisal as I'm told. I will always ask if I'm unsure about anything and the managers are always very happy to help." Another staff member said "Because my manager tells me so and always says well done which is great." This was a marked change of culture for the home where staff had felt unable to question things or received any praise under the direction of the previous registered manager. Staff meeting minutes included discussions around appropriate staff conduct, planned changes in the home and its management and correct medication procedure.

We asked the registered manager what they felt their key achievements had been since the last inspection. The registered manager spoke with us about their changes to empower the staff to take more leads. They said they delegated specific tasks to the deputies and senior care staff to ensure a more even spread of responsibility and increase the likelihood of things not being missed. They had also developed a positive relationship with the registered provider who was keen for the home to succeed. There had been substantial investment in the environment which we noted and the registered manager felt with the regular risk register audits it was clear where the need for further work was required and could be planned better.

The registered manager was being supported by an external consultant who visited the home on a bi-monthly basis and who provided guidance and support for the registered manager who was fairly new to the role. However, they had completed their NVQ level 5 in management since the previous inspection showing their intention to be fully trained and knowledgeable about their role. The registered manager had found this support invaluable and it was evident from the overall improvements this had had some significant impact.

The registered manager knew everyone very well. Their interest in people's wellbeing was evident in the many discussions we had about specific people ranging from their health and medical needs through to their social and wider familial relationships. The registered manager had advocated on behalf of a few different people in the home in different situations, ensuring their rights were upheld and it reinforced the view they were person-centred and working in people's best interests.

We found a programme of regular maintenance checks in place such as weekly tap flushing for unoccupied rooms and window restrictor tests. One room was out of action as the window needed replacing and the registered provider was aware of this. All rooms were checked on a regular basis for any concerns and these were responded to promptly. These checks included mattress audits, bed rails, nurse call system, wheelchair checks and lighting which are all key elements of ensuring people's safety and comfort. The home had all necessary safety checks in place such as portable appliance testing, legionella, gas, emergency call systems and electric. We saw evidence of any concerns acted upon quickly.

There was a robust quality assurance system in place which considered internal and external audit findings incorporating equipment, safeguarding, accidents, falls and weight monitoring. All these helped identify any trends and showed action had been taken where concerns were noted.

The registered manager had also implemented a monthly programme of audits including infection control, health and safety, catering and medication. Each was very comprehensive and addressed areas in depth. Actions arising from these audits were noted on an action plan and evidence was seen some had been completed. We pointed out to the registered manager not all were noted as completed, although we found they were, and they agreed to ensure this was reflected on future audits. Where actions involved staff needing further training or guidance, this had been arranged or offered through staff meetings and supervision.

A risk assessment register had been developed by the registered manager to ensure all tasks which needed completion such as repairs to items in the home were logged, reported and timescales set for completion. We saw this in use as a working document. It included how the risks were to be mitigated and what plans were in place to remove the risks wherever this was possible.

The home was, in May 2017, about to become involved in the Vanguard project being run by Wakefield's Clinical Commissioning Group. This is a project to avoid unnecessary hospital admissions from care homes and to provide support and guidance where needed to improve the quality of life for people in care homes. The registered manager was looking forward to the potential of considering new ways of supporting people to live fuller lives. A visiting health professional told us "The registered manager is very keen to work with us. The home has improved and I have never seen anything of concern. It is much more organised."