Regency Healthcare Limited

The Laurels Care and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

We last inspected The Laurels Care and Nursing Home on the 4 October 2013 to check whether requirements relating to staffing had been met. Prior to this we had visited the service on 12 July 2013.

This inspection took place on 24 and 26 March and 1 April 2015 and was an unannounced inspection which meant the provider and staff did not know we were coming. The home is registered to provide care for up to 28 people. At the time of our visit there were 22 people living in the home. The home was providing care for older people including people living with dementia and people with nursing care needs.

The registration requirements for the provider stated the home should have a registered manager in place. There was no registered manager in post on the day of our inspection. The Care Quality Commission has however

Summary of findings

received an application from the home manager to register as registered manager. 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 asked people who used the service if they felt safe in the home and if they had any cause to be concerned about how they were treated. Some people could not express their views and family members spoke on their behalf. One relative said, "I think they (staff) are very patient with people. They deal with all sorts of challenges on a daily basis. They work hard." Another relative told us, "They do their best. I would know if there was anything untoward regarding her care. She is always clean and tidy when I visit. I find the staff to be well mannered and caring."

We were concerned over the risk of bedroom locks being used when staff were not issued with master keys. This meant staff could not enter people's bedrooms easily in an emergency situation. You can see what action we told the provider to take at the back of the full version of the report

We found individual risks had been identified and recorded in people's care plans. However we found records used to support staff to monitor risks such as skin integrity and nutrition were not being completed properly This placed people at increased risk of not receiving the right care and support. You can see what action we told the provider to take at the back of the full version of the report.

Each person had an individual care plan. These were sufficiently detailed to ensure people's care was personalised and they were kept under review. Staff discussed people's needs on a daily basis and people were given additional support when they required this. Communication between staff needed to improve to be effective and help make sure people received safe and effective care. Referrals had been made to the relevant health professionals for advice and support when people's needs had changed. This meant people received co-ordinated care.

People we spoke with told us they had their medicine when they needed it. We found medicines were managed well and appropriate arrangements were in place in relation to the safe storage, receipt, administration and disposal of medicines.

People were cared for by staff that had been recruited safely and were both trained and receiving training to support them in their duties. We heard positive comments about the staff and we observed staff were respectful to people and treated people with kindness in their day to day care. One person told us, "I am spoilt, I'm well looked after and have nothing at all to grumble about." Relatives we spoke with described staff as being 'kind', 'thoughtful' and 'very good'.

People we spoke with had mixed views about the staffing levels and availability of staff. They said, "There seems to be plenty of staff around." One relative commented, "There is not enough staff around." We were given an example of how they felt this had impacted on their relatives care. There appeared to be plenty of staff on duty but how staff were deployed meant that at times people were left unattended. The manager dealt with this immediately.

We undertook a tour of the building. The home was clean and hygienic in most areas; however we found acceptable standards of hygiene had not been maintained in three people's bedrooms and on one corridor. Plans had been made to improve the environment with dementia care needs in mind and there was evidence work had commenced. For example the patterned carpet in the communal areas was to be replaced and some bedrooms had been refurbished. Some of the bedrooms needed redecorating as they were sparse and basically furnished. We found there was ongoing work to upgrade the premises and create a more dementia friendly environment for people living with dementia. Specialist equipment in use was clean and maintained.

Staff told us they were confident to take action if they witnessed or suspected any abusive or neglectful practice and had received training about the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). The MCA 2005 and DoLS provide legal safeguards for people who may be unable to make decisions about their care. We noted appropriate DoLS applications had been made to ensure people were safe and their best

Summary of findings

interests were considered. Staff were aware of people's ability to make decisions for themselves and knew the principles of having best interest decisions made to support and protect people. We were told the provider was 'generous' when it came to food. Staff were made aware of people's dietary preferences and of any risks associated with their nutritional needs. People's weight was checked at regular intervals and we saw appropriate professional advice and support had been sought when needed. Staff supervision however was not effective in making sure people had the support they needed at mealtimes which means people may be at risk of not receiving adequate nutrition. This was addressed by the manager during our visit.

We have made recommendations about meeting nutritional needs.

Staff were seen to be patient, friendly and supportive when they were helping people. We noted people were well dressed with attention given to detail with personal touches such as wearing makeup and jewellery. This helped to support people retain their identity and dignity. One relative told us, "He has always liked to look smart. He is always clean and tidy when I come and dressed in the clothes he likes."

People had been given the opportunity to discuss and document their wishes regarding end of life care. This meant people and those who matter to them could have peace of mind knowing their wishes were made known to staff.

Activities provided were limited and included entertainers visiting the home and usual festive and birthday celebrations. We were told the activity co-ordinator recently employed in this position was to have training. We were given details of plans they had made to improve this and people would have a personalised plan to help them engage in daily life. Visiting arrangements were good and visitors told us they were made to feel welcome.

We have made a recommendation about improving activities provided for people.

There was a clear complaints procedure. This was displayed for all to see together with other useful information such as advocacy services. People were encouraged to discuss any concerns during meetings, during day to day discussions with staff and management and also as part of the annual survey to give feedback on the service provided.

People told us the management of the service was good. The manager was relatively new and had applied to be registered as a registered manager with CQC. Staff commented, "The manager is lovely. We can always talk to her. She is very approachable." "She's very much hands on to help us when we need it. I could go to her with any problem and I know she will listen." "Yes, she is nice and I can knock on her door at any time; I have no problems. If I want to see the owners they never turn me away and they are always around."

There were informal and formal systems to assess and monitor the quality of the service which would help identify any improvements needed and provide an opportunity for people to express their views. However these were not entirely effective. Completed quality monitoring with people using the service showed an overall satisfaction with the service.

We have made a recommendation about ensuring improved systems were in place to effectively monitor the quality of the service provision.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

Locks on bedroom doors were not safe because staff did not have master keys to override the locks in an emergency.

Record keeping required improvement to make sure people at risk of poor nutrition and skin integrity were monitored better.

Safe recruitment practices were followed and contractual arrangements and policies and procedures for people's protection were in place.

Medication was managed safely.

Is the service effective?

Requires Improvement

The service was not entirely effective.

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Appropriate action was taken to make sure people's rights were protected. Decisions made took into account people's views and values. People had access to healthcare services and received healthcare support.

Staff were supervised on a daily basis. All staff received a range of appropriate training and support to give them the necessary skills and knowledge to help them look after people properly and support people's changing needs.

People were not adequately supervised and supported to have sufficient to eat and drink and maintain a balanced diet. Food served was nutritious and plentiful and people told us they enjoyed their meals. We were told the provider was generous with the supply and quality of food provided.

Is the service caring?

Good

The service was caring.

We found staff were patient, friendly and supportive when they were helping people.

People were supported to maintain their identity and were treated with dignity.

People and those who matter to them could have peace of mind knowing their end of life wishes were made known to staff.

Is the service responsive?

Good

The service was responsive.

People's health and well-being was monitored. Appropriate advice and support had been sought in response to changes in their condition.

Summary of findings

People's needs had been assessed before they were admitted to the service. They had a personalised care plan, which provided guidance for staff on how to meet their needs. Some activities were being provided and an activity co-ordinator had recently been employed in response to an identified need.

People had access to the complaints procedure and were invited to give their views in quality monitoring surveys.

Is the service well-led?

Requires Improvement

The service was not entirely well led.

The manager and provider had reviewed all the practices and made changes that were on-going to promote values of trust, respect and care being maintained.

The manager liaised with other professionals to develop the service.

The registered provider provided the resources and support needed to enable and empower the staff team to develop. Quality assurance processes were not sufficient in identifying shortfalls in systems that impacted on people's health and welfare.

The Laurels Care and Nursing 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24 and 26 March and 1 April 2015 and was unannounced.

The inspection team consisted of one adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service and has nursing experience.

Before the inspection we reviewed the information we held about the service that included notifications we had received prior to our visit. We contacted the health and social care professionals and were not provided with any information about the service that we did not already know about.

Before the inspection, the manager completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and the improvements they plan to make.

We spoke with eight people living at the home, six relatives, four care staff, one registered nurse, two ancillary staff, the cook, the manager and a senior representative from the company known as a Nominated Individual (NI). We observed care and support in communal areas and also looked around the premises and in some people's bedrooms. 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 sample of records including three people's care plans, other care associated documentation, recruitment and staff records, medication records, policies and procedures and quality audits.

Inadequate

Is the service safe?

Our findings

We spoke with eight people using the service and with six relatives who regularly visited the home. Two of the eight people we spoke with were able to tell us what it was like for them to live at the home. They told us they were cared for very well and never had any cause to feel concerned. One person when asked if they felt safe said, "Yes, I'm nice and comfortable." We asked people living in the home and visitors to the home if they had ever had cause for concern with regard to how staff treated them and other people using the service. One relative said, "I think they (staff) are very patient with people. They deal with all sorts of challenges on a daily basis. They work hard." Another relative told us, "They do their best. I would know if there was anything untoward regarding her care. She is always clean and tidy when I visit. I find the staff to be well mannered and caring."

We were unable to talk to some people as they had difficulty in expressing their views and showed limited understanding of questions we asked them. To help us understand what their experience was of the care and support they received, we spent time in all areas of the home. This helped us to observe the daily routines and gain an insight into how people's care and support was delivered and managed. We used the SOFI. We observed for example people were able to walk about freely within the home and were comfortable around staff.

We saw there were suitable policies and procedures for infection control in the home and staff had received appropriate training in this area. We observed staff wore protective clothing such as gloves and aprons and soap and sanitiser dispensers were installed throughout the home to minimise cross infection. Bathrooms, toilets and sluice rooms were clean. Environmental Health had visited the home and awarded a five star rating for food hygiene. There were contractual arrangements for the disposal of clinical and sanitary waste. We saw that regular audits were being carried out for the control of infection but had not picked up the shortfalls evident in rooms.

We looked at some of the equipment that was available in the home. This included for example wheelchairs, hoists, stand aid, and bedrails. We found these were kept in good order and were clean. We observed staff used equipment correctly to meet statutory requirements and to keep people safe. Staff confirmed they had been trained in safe moving and handling and to use the hoist.

We found maintenance of the home was on-going. Bedrooms were being decorated. However we noted that two sash window frames in bedrooms were rotten and there were holes in areas of plasterboard of the internal walls. The patterned carpet on the ground floor was problematic for two people living with dementia as they were bending down to the floor and making gestures of picking things up. We had received information prior to our visit from the manager this was to be replaced with a plain design of flooring. Other changes were planned for that would create an environment suitable for people living with dementia.

One relative raised a concern with us regarding the bedroom door locks and was upset as he had found gentleman's slippers under his wife's bed. We checked the locks on bedroom doors. They were the type that allowed people to lock their room for privacy and allow staff to gain access in an emergency by overriding the lock with the matching door key. We were concerned about the lack of master keys for staff to gain access into people's rooms as this placed people at risk in an emergency situation. We discussed this with the senior representative of the company and manager who agreed to purchase master keys. Otherwise, security to the premises was good and visitors were required to sign in and out.

We found the registered person failed to take all reasonable steps to ensure the safety of people using the service. This was a breach of Regulation 12(1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Cleaning schedules were in place for all areas of the home including the kitchen to help ensure that a high standard of cleanliness was maintained. We discussed the housekeeping arrangements in the home with the manager and registered provider as we found three bedrooms that were not cleaned to an acceptable standard. Some commodes were malodorous and two had splashes of excreta in the bowls and stains on their padded tops and seats. We turned back one bed. The bottom sheet was stained with what looked like excreta. There was also an unpleasant odour on one of the corridors leading to bedrooms.

Inadequate

Is the service safe?

We found the registered person failed to ensure parts of the premises were clean and free from odours that are offensive or unpleasant. This was a breach of Regulation 15(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found individual risks had been identified and recorded in people's care plans. Details of risk and management strategies outlining action to be taken to minimise risk was recorded. However we found body maps, which would show the date, size and position of any damage to the skin such as bruising, water lesions or pressure sores, had not been completed properly. We also noted when staff had reported lesions or skin problems to the nurse in charge, there was no evidence in following daily records that this had been discussed or of any action taken to address the problem. We saw food and fluid intake charts were not being completed accurately. The lack of appropriate and correct information being recorded in care notes could potentially place people at increased risk of not receiving the right care and support.

We found the registered person failed to make sure records were complete, accurate and updated. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed safeguarding procedures with six members of staff and with the manager and deputy manager. All staff spoken with told us they had received appropriate safeguarding training and had an understanding of abuse. They confidently told us what action they would take if they witnessed or suspected any abusive or neglectful practice. There were policies and procedures in place for their reference including whistleblowing. Whistleblowing is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest'.

People we spoke with told us they had their medication when they needed it. We looked at how medicines were managed and found appropriate arrangements were in place in relation to the safe storage, receipt, administration and disposal of medicines. Arrangements were in place for confirming people's current medicines on admission to the home. We found the home used a monitored dosage system of medication. This is a storage device designed to simplify the administration of medication by placing the medication in separate compartments according to the time of day. Medication was delivered pre packed with corresponding Medication Administration Records (MAR) sheets for staff to use.

We looked at MAR sheets and noted safe procedures were followed where hand written records of medication were used. We found that where new medicines were prescribed, these were promptly started and that sufficient stocks were maintained to allow continuity of treatment. People requiring urgent medication such as antibiotics received them promptly. There were arrangements with the supplying pharmacy to deal with medication requirements such as these and medicines no longer required were disposed of appropriately. All records seen were well maintained, complete and up to date and we saw evidence to demonstrate the medication systems were checked and audited on a regular basis.

Appropriate arrangements were in place for the management of controlled drugs. These are medicines which may be at risk of misuse and require extra monitoring. Controlled drugs were stored appropriately and recorded in a separate register. We checked four people's controlled drugs and found they corresponded accurately with the register. Care records showed people had been asked how they wanted their medication managed and this was kept under review. Where medicines were prescribed 'when required' or medicines with a 'variable' dose, guidance was recorded to make sure these medicines were offered consistently by staff. Medicines required at different times during the day were also managed well. The manager told us all staff designated to administer medication were qualified and had completed training. Staff confirmed this.

During the inspection we observed there was enough staff available to attend to people's needs. However, we noted how staff were deployed meant that at times people were left unattended. We discussed this with the manager and the senior representative of the company who both agreed they would look into this matter as they had increased staffing levels and changed shift patterns to make sure this would not occur. On the second day of our visit we saw there had been some improvement.

We looked at three staff recruitment files. We found completed application forms, references received and evidence the Disclosure and Barring Service (DBS) checks were completed for applicants prior to them working. The

Inadequate

Is the service safe?

DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This check helps employers make safer recruitment decisions. There was a policy of non-acceptance of gifts staff were obliged to follow. This meant people could be confident they had some protection against financial abuse and this was closely monitored.

People we spoke with had mixed views about the staffing levels and availability of staff. Comments from relatives included, “There seems to be plenty of staff around.” “Yes, there are enough for her, but sometimes there seems less staff.” One relative commented “There is not enough staff around.” We were given an example of how they considered this had impacted on their relatives care.

We asked the manager about the current staffing arrangements. We were told the numbers of staff on duty had recently been increased and two new staff had been recruited. They were waiting for the relevant character checks to be completed before they started work. The manager told us any shortfalls, due to sickness or leave, were covered by existing staff or as a last resort by agency staff that were familiar with the home. This helped to ensure people were looked after by staff who knew them.

We had spoken with the domestic on duty who explained she had been on her own for most of her shift and had not completed the more in depth cleaning. There were usually two domestic staff on duty and this made a difference. The manager told us occasionally a staff member was called to work in another home belonging to the provider in an emergency. On the second day of our visit we noticed an improvement and two domestic staff were on duty. We discussed the impact of using domestic staff between homes. The senior representative of the company acknowledged this was not good practice and would make sure it would not be a regular feature.

Requires Improvement

Is the service effective?

Our findings

The people using the service we spoke with offered no criticism of the qualities of the staff who cared for them. They made positive comments such as, "They are lovely", and "Very kind to me". We asked visiting relatives to comment on the qualities of staff. One relative said, "I find them to be really caring. I couldn't manage to care for him at home and I'm happy the way things are. They know him very well." Another said, "Mum resists personal care; she resisted more at the other home. There would be no way of forcing her as it would distress her further, but here they seem to be able to care."

We looked at how the service trained and supported their staff. From our discussions with staff and from looking at records, we found staff received a range of appropriate training to give them the necessary skills and knowledge to help them look after people properly. The manager told us the provider was extremely supportive with staff regarding their training.

Records we looked at showed there was an induction and training programme for new staff which would help make sure they were confident, safe and competent. This included a review of policies and procedures, initial training to support them with their role and shadowing experienced staff to allow them to develop their skills. Staff we spoke with told us they had a good induction training when they started work.

Staff told us they considered they were adequately supervised on a day to day basis. Most staff had achieved or working towards a recognised qualification in care. One member of staff said, "We have a good staff team and we are supported very well. I've never been asked to do anything I'm not trained to do and if I'm unsure about anything I only have to ask. I really enjoy my job."

Staff we spoke with had a good understanding of their role and responsibilities, and of standards expected from the manager and registered provider. They said they had handover meetings at the start of their shift and were kept up to date about people's changing needs and support they needed. Records however showed important key information was not necessarily shared between staff. We discussed this with the manager and senior representative of the company. The manager told us a meeting had been held with the staff regarding this following the second day of our visit. As a result more accountability for practice was being introduced and staff in charge were responsible to check all records made on a daily basis.

We looked at pre admission assessments for three people recently admitted. We found information recorded supported a judgement as to whether the service could effectively meet their needs. Furthermore people had received a contract outlining the terms and conditions of residence that explained their legal rights.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). The MCA 2005 and DoLS provide legal safeguards for people who may be unable to make decisions about their care. It sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected and ensures the least restrictive option is taken. The Care Quality Commission (CQC) is required by law to monitor the operation of DoLS. Staff we spoke with showed an awareness of the need to support people to make safe decisions and choices for themselves. They had an understanding of the principles of these safeguards and had received training on the topic. We were given examples of the use of this such as delivering personal care. At the time of the inspection two people using the service were subject to a DoLS. This was being managed in accordance with best practice published guidance and being reviewed regularly. The manager told us she was in the process of ensuring all people who required an application for DoLS were identified and the process was on-going. This would ensure people were protected against the risk associated with any unlawful deprivation of their liberty.

Care records showed people's capacity to make decisions for themselves had been assessed on admission and useful information about their preferences and choices was recorded. This provided staff with essential knowledge to support people as they needed and wished and preference for gender of carer was also recorded. Staff spoken with had a good understanding of people's needs, interests and preferences. Staff were also aware of people's ability to make safe decisions and choices about their lives. Information we received from the manager prior to this inspection informed us that in addition to preferences and choices, new paperwork introduced into care plans would address residents' personal preferences better and support

Requires Improvement

Is the service effective?

staff deliver the best possible care and promote a good quality of life for people using the service. We saw that 'Who am I' documents were being completed that should support a more personalised approach to people's care.

The registered manager told us several people had 'Do Not Attempt Resuscitation' (DNAR) consent forms in place. We discussed the protocol that had been followed to deal with this and looked at two people's records. We established a best practice approach was taken and the General Medical Council's MCA code of conduct and practice followed when the decision was considered and the person's views and values taken into account. These had been reviewed periodically.

We looked at how people were supported with their health. People's healthcare needs were considered during the initial care planning process and as part of on-going reviews. Records also showed routine health screening was planned for and records were completed following healthcare visits. We found staff at the service had good links with other health care professionals and specialists to help make sure people received prompt, co-ordinated care. A person using the service and visiting relatives confirmed health care was managed well. One person told us, "The lady doctor comes to see us all."

We looked at how people were protected from poor nutrition and supported with eating and drinking. One person using the service said, "Its lovely food, I've got nothing to grumble at." When asked people if they could choose their meals, they replied "No, they make it." They also said, "We have sandwiches for tea; we are not short of food." Another person told us, "On the whole the meals are good. We can have what we want. I've ordered a salad today. I don't want a hot meal."

We observed lunchtime. We saw some people were being given the support and encouragement they needed to eat their meal. People requiring staff assistance were given one to one attention. Some people however, who were not dependent on staff to support them were left without mealtime supervision. As a result staff were unaware of people's table habits. For example, meals were not fully eaten, one person threw food about, and three other people were observed not using their cutlery correctly. We discussed this with the senior representative of the company and manager and we recommended that the deployment of staff be reviewed. A protected meal time was in place. Visitors were requested not to visit unless they were specifically supporting their relative eat a meal. This was to reduce the level of activity at meal times.

Care records included information about people's dietary preferences and of any risks associated with their nutritional needs. People's weight was checked at regular intervals and we saw appropriate professional advice and support had been sought when needed. Where risk of poor nutrition was identified, staff completed food and fluid intake charts. These should help staff to be alerted where there were any difficulties. We checked these records following our observations of lunch time. We saw these had not been completed correctly and did not reflect a true record of actual food taken. One relative we spoke with told us that their relation had lost weight. We discussed these issues with the manager who told us staff had been instructed to complete charts properly. Drinks were to be provided at regular intervals to reduce the risk of infections. On the second day of our visit the manager told us she had addressed the issues we raised. As a result of our findings staff had been alerted to the shortfalls we had observed and an action plan was put in place to address this immediately. Staff supporting people were required to complete the records following the meal and told to indicate quantities of food accurately. People were to be supervised throughout the meals.

We spoke with the cook on duty. They told us they worked to a four week menu and changed menus to suit people's preferences. All meals and confection were homemade and there was some flexibility within the menu. Fresh produce was used and there was always sufficient supplies ordered. We were told the provider was 'generous' when it came to the supply and quality of food and they could order what they needed and what people wanted.

We undertook a tour of the building. People could access all areas of the home and there was adequate wheelchair access. The upper floor could be accessed via a passenger lift. We looked in people's bedrooms and saw some had been nicely decorated and had evidence of personal items and mementoes in them. However some of the bedrooms were sparse, basically furnished and in need of decorating. The senior representative of the company and manager told us they were currently upgrading rooms. They had informed us of their plans to create a more dementia friendly environment. These included for example,

Requires Improvement

Is the service effective?

replacement of patterned carpets, and alternative flooring for some areas such as non-slip and easy clean. They also acknowledged the décor required some adjustment to support people living with dementia, and more contrast colours were to be introduced.

We recommend that the service seek advice and support from a reputable source, about supporting people to have enough to eat and drink.

Good

Is the service caring?

Our findings

From our observations over the three days we were at the home, we found staff were respectful to people and treated people with kindness in their day to day care. One person told us, "I am spoilt, I'm well looked after and have nothing at all to grumble about." Relatives we spoke with described staff as being 'kind', 'thoughtful' and 'very good'. One relative said, "The care is satisfactory, Mum has not been here long enough for me to really know, but I had heard good reports about it and it is close to me. She is calmer here and she looks comfortable." Another relative told us, "The care is fine; they care, they look after her and she is always clean."

Staff we spoke with had a good understanding of people's personal values and needs. They knew what was important to people and what they should be mindful of when providing their care and support. One staff member said, "I enjoy working here. I think everyone is well cared for. We do our best for them and everything we do is with them in mind. We would like to spend more time with people but we are busy all the time." Another staff member said, "There is a lovely atmosphere and people are looked after very well." The senior representative of the company and manager told us how they intended to further improve the delivery of care by educating staff and applying a more flexible approach to service delivery. They also intended to introduce a 'resident day' when each person will have a day set aside for them as their special day.

We observed staff were seen to be patient, friendly and supportive when they were helping people. In general staff communicated well with people. However we noted that on occasions such as when transferring people with the hoist and supporting people with their meals, staff did not take the opportunity during this one to one time to engage with people they were supporting. We told the manager of our observation. We observed staff discreetly supporting people to use the toilet in a manner that helped them maintain their dignity and privacy.

We noted people were well dressed with attention given to detail. For example their clothes were clean and nicely pressed. Other personal touches that supported people maintain their identity and keep their dignity was considered, such as wearing makeup and jewellery and having clean neatly trimmed manicured finger nails. One relative told us, "He has always liked to look smart. He is always clean and tidy when I come and dressed in the clothes he likes."

There was a range of information displayed at the service. For example information about health services, social care and information about advocacy services. People had a guide to The Laurels Care and Nursing Home which included useful information about the services and facilities available to them during their stay.

We found several staff had received training in end of life care and we were told all staff would complete this. Care records showed people had been given the opportunity to discuss and document their wishes regarding end of life care. This meant people and those who matter to them could have peace of mind knowing their wishes were made known to staff.

Good

Is the service responsive?

Our findings

We looked at assessment records for three people. The assessments had been carried out by the manager. Information had been gathered from a variety of sources such as social workers, health professionals, family, and also from the individual. We noted the assessment covered all aspects of the person's needs, such as physical and mental health, personal care, mobility, nutrition, daily routines and communication. People's capacity to make decisions was also included. A 'This is me' supplementary profile was used which provided staff with some insight into people's needs, expectations and life experience. The way people with limited capacity to use words communicated their wishes was recorded, for example, 'has anxiety receiving personal care from male staff'. This meant the persons' wish for a female carer was clear. Where people needed support in making decisions family wishes were considered and emergency contact details for next of kin or representative were recorded in care records as routine.

People were able to visit the home and meet with staff and other people who used the service before making any decision to move in. This allowed people to experience life in the home and consider if the services and facilities on offer met with their needs and expectations.

We looked at three care plans and also looked at continuing assessments of five other people living in the home. These were very well written and clearly placed people at the centre of their care and included descriptions of the support required to meet people's individual needs such as mobility, pressure relief, sleep, hobbies, activities, dying and mental health. They were specific in instruction for staff to make them personal for individuals. There was evidence care plans were being reviewed regularly. We asked relatives visiting if they were consulted about care plans. We had a mixed response. One relative told us, "Yes, they often talk to me about her care. I trust them explicitly and they tell me how she has been. I'm always asked what I think." Another relative told us, said, "Here, I have to ask for example, 'Has she had a shower?' or 'How she is?' No-one comes to update me on what has happened. They don't tell me the little things that she has done."

Risk assessments were reviewed monthly and we noted these reviews had led to the involvement of healthcare professionals when appropriate. For example we saw a referral to the dietician was made where dietary problems were identified.

We noticed daily records were written to record the care and support people had received. We discussed the quality of records being written with the manager as they often referred to `all care as plan, no changes' despite supplementary records showing changes and referrals being made to other professionals. The manager told us this was currently being addressed. We asked the manager how essential information was relayed when people use or move between services such as admission to hospital or attended outpatient clinics. We were told staff would escort people if needed and all relevant details were taken with them. Any information or guidance from the hospital, GP or outpatients was recorded and discussed to support people's continuing care. We saw evidence reports were made of visiting health and social care professionals.

People we spoke with told us there had been little or no activities taking place. One person said, "There are dominoes but I watch tele." We spoke with two relatives visiting. They said, "There's nothing going on." And "There's not much in that way. There was a man who organised something with a ball but he's gone." We observed the activity co-ordinator helping three people to make Easter cards from a ready prepared 'kit.' One of the three seemed actively involved, the others less so but she was patient and gentle with them. When asked if she had had any training in organising activities she said, "I'm going to go on a course to do with organising activities. I have time allocated for activities and I am a carer too." She explained she had not been in the activity post for long and was confident activities would be developed. We were given examples such as one to one activities, memory boxes, and personalised activities bases on people's known interests. We looked at the activity record that was kept. This showed the level of organised activity provided was limited. We found the home to be very quiet and noticed televisions were on in both lounges. We did observe some very good practice however in providing one person living with dementia a cloth to wipe tables down. It was clear this was an enjoyable experience for them.

People's assessment included hobbies and interests. We saw for example people enjoyed church, soft music,

Good

Is the service responsive?

animals, dogs, pictures and magazines. The activity co-ordinator told us each person would have a personalised plan to help them engage in daily life. Staff told us activities were provided regularly such as entertainers visiting the home and usual festive and birthday celebrations.

We looked at how staff supported people to maintain relationships with their friends and families. Visiting was open and visitors were asked to respect their protected meal time for people but invited to support their family members to eat. Relatives we spoke with told us they were made to feel welcome. One relative told us, "I come often. They make me feel welcome and I always get offered a drink." One person using the service told us they had no relatives and said, "I have plenty of friends in here, we all mix in together and we are not short of anything."

The service had a complaints procedure which was made available to people they supported and their family members. The manager told us they welcomed any comment or complaint about the service as it helped improve their customer service. People who used the service and their relatives had opportunity to discuss their concerns during meetings, during day to day discussions with staff and management and also as part of the service satisfaction survey.

Requires Improvement

Is the service well-led?

Our findings

The manager had not been in post very long. We spoke with her on the day of our inspection and was told us they had submitted an application to register as registered manager for the home with the Care Quality Commission. We confirmed this process was taking place following our inspection. The senior representative of the company told us they were working closely with the manager to support the changes she had identified that would improve the service.

The manager told us they kept up to date with current good practice by attending training courses and linking with appropriate professionals in the area. For example the manager was working with one of the GP practice regarding dementia care. The manager also told us about the review of all practices and changes they had made to promote values of trust, respect and care being maintained. This included for example, changes in the way staff were recruited to support them to appoint people who had the right characteristics and qualities to deliver personalised care and routines and staff rotas had been changed to benefit people using the service in order to receive a more flexible approach to their care and quality of life experience. We found it encouraging that prior to this inspection the manager submitted a PIR that had informed us in an open and transparent way of all the development work that was needed to improve the service, such as better communication and an improved environment.

We found there were effective systems in place to seek people's views and opinions about the running of the home. People living in the home and their relatives were asked to complete customer satisfaction surveys. This enabled the home to monitor people's satisfaction with the service provided. We looked at samples of returned questionnaires that showed an overall satisfaction with the service. The manager told us she had arranged a resident/ relative meeting but this was poorly attended. Plans were in place to hold 'coffee mornings' for relatives and to promote a more inclusive service for everyone.

Staff indicated they were happy with the management arrangements. They told us, "We all work very well together. We know what we need to do when we start work. The nurse in charge delegates us into two teams." And "The manager is lovely. We can always talk to her. She is very approachable." "She's very much hands on to help us when we need it. I could go to her with any problem and I know she will listen." Other comments referring to the manager included, "Yes, she is nice and I can knock on her door at any time; I have no problems. If I want to see the owners they never turn me away and they are always around."

Staff were aware of their roles and responsibilities. We found there were processes in place to support the manager to account for actions, behaviours and the performance of staff. Accountability for staff performance was evident with check lists completed for daily tasks and personal care provided. However we discussed the failing of senior staff who oversee staff performance and ensure records were kept up to date. The manager told us this had been addressed immediately and they intended staff would take more responsibility such as having lead roles in various topics such as dementia care, infection control, health and safety, medication and safeguard. This would help to ensure staff were kept up to date with best practice. The senior representative of the company and manager told us support and resources were available to enable and empower the staff team to develop the service.

There were systems in place to regularly assess and monitor the quality of the service. They included checks of the medication systems, care plans, money, activities, staff training, infection control and the environment. However some of these there were not effective in recognising and identifying areas in need of improvement. Guidance was also followed such as health and safety in the work place, fire regulations and control of hazardous substances. All accidents and incidents which occurred in the home were recorded and analysed to identify any patterns or areas requiring improvement.

Information we hold about the service indicated the manager had notified the commission of any notifiable incidents in the home in line with the current regulations.

We recommend the service take advice and guidance from a reputable source on how to ensure effective operating systems are in place to monitor the quality of the service provision.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People who use services were not protected against the risks associated with bedroom locks, as master keys for staff had not been supplied. Regulation 12(1)(2)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The provider had not kept all parts of the premises clean and free from offensive odours. Regulation 15(1)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We found the registered person failed to make sure records were complete, accurate and updated.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.