CCA & Mrs C Bolland

Laurel Mount

Inspection report

Woodville Road
Keighley
West Yorkshire
BD20 6JB

Tel: 01535667482

Date of inspection visit:
05 May 2017

Date of publication:
24 May 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

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

The inspection was unannounced and took place on the 5 May 2017. On the date of the inspection there were 25 people living in the home.

At the last inspection in February 2016 we rated the provider 'requires improvement' in the 'effective' and 'responsive' domains and overall. This was because of issues identified with training, nutritional and general care planning. At this inspection we found improvements had been made.

People, relatives and health professionals praised the home and the standard of care provided. People valued the person centred approach practiced by the home and the warm and friendly environment created by the registered manager and the staff team.

Medicines were managed in a safe and proper way and people received their medicines as prescribed when they needed them.

There were enough staff on duty to ensure people received prompt care and support and were appropriately supervised. Staff were recruited safely to help ensure they were of suitable character to work with vulnerable people.

Risks to people's health and safety were assessed and risk assessments were subject to regular review. People said they felt safe in the home and staff understood how to keep people safe.

The premises was warm, homely and well maintained to ensure it remained safe and appropriate for its use. We identified the dining facilities could be improved to make the dining experience more positive.

People said staff had the right skills and knowledge to care for them. There was a low turnover of staff which allowed staff to develop a good understanding of the people they were caring for. Staff received regular training and support.

The service was acting within the legal framework of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Best interest processes were followed where people lacked capacity.

People had access a range of nutritious food that met their individual needs and requirements. Action was taken to protect people from the risk of malnutrition.

Healthcare needs were assessed and the service worked with a multidisciplinary team to meet people's

needs.

People said staff were kind and caring and treated them well. Staff had developed good positive relationships with people and knew them well.

People said they felt listened to by staff. We found a warm, inclusive and person centred atmosphere within the home.

People's care needs were assessed and appropriate care provided to people in line with their assessed needs. People's preferences were taken into account during care planning and delivery.

People had access to activities and social opportunities. An activities co-ordinator was employed who undertook a range of activities within the home.

People and relatives were very satisfied with the service. People said the registered manager dealt with any minor issues in a positive and thoughtful way. A system was in place to log, investigate and respond to complaints.

An experienced registered manager was in place who was dedicated to providing high quality care and ensuring continuous improvement of the service.

People, relatives and health professionals all said the service was well led. Staff said morale was good and the team worked well together.

A system of audits and checks were undertaken to ensure the service operated safely and effectively. People's feedback was used to make improvements to the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were managed in a safe and proper way. People received their medicines when they needed to.

People felt safe living in the home. Risk assessments were undertaken and regularly reviewed to reduce the risk to people.

There were enough staff deployed to ensure people received timely care and support. Robust recruitment procedures were in place to ensure staff were suitable to work with vulnerable people.

Is the service effective?

Good

The service was effective

There was a stable staff team who received a range of training and support.

People's nutritional needs were monitored and well met by the service.

The service was working within the legal framework of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's healthcare needs were met in conjunction with a multidisciplinary team.

Is the service caring?

Good

The service was caring.

People and relatives said staff treated them well and were kind and friendly.

People felt listened to by staff. Staff had developed good relationships with people and knew them well.

Staff helped to promote and maintain people's independence

where appropriate.

Kind, compassionate and individualised end of life care was provided by the home.

Is the service responsive?

Good

The service was responsive.

People and relatives spoke positively about the standard of care provided. People's needs were assessed and person centred care plans put in place, respectful of people's preferences.

An activities co-ordinator was employed and people had access to a range of activities.

People and relatives were very satisfied with the service and said minor issues were dealt with appropriately by the manager. There was a low instance of complaints.

Is the service well-led?

Good

The service was well led.

An experienced registered manager was in place. Staff, people, relatives and health professionals all praised the registered manager and said they were approachable and effective in their role.

Staff morale was good and the team worked well together.

People and relatives were very satisfied with the care and support provided. Systems were in place to assess, monitor and continuously improve the service.

Laurel Mount

Detailed findings

Background to this inspection

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

The inspection took place on 5 May 2017 and was unannounced.

The inspection was carried out by two inspectors and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience used had experience in services for older people and those living with dementia.

Before the inspection we reviewed the information we held about the service. This included looking at information we had received about the service and statutory notifications we had received from the home. We contacted the local authority safeguarding and commissioning departments to get their views on the service. We received feedback from three health professionals who regularly work with the service.

We used a variety of methods to gather information about people's experiences. We observed care and support and 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.

During the inspection we spoke with five people that used the service and five relatives. We looked at the way people's medicines were managed, looked in four people's care records and viewed other records relating to the management of the service such as maintenance records and meeting notes. We looked at staff files and training records. We looked around the home at a selection of people's bedrooms and the communal areas. We spoke with a registered nurse, six care workers, the cook, the kitchen assistant and the registered manager.

Good

Is the service safe?

Our findings

Medicines were managed in a safe and proper way. People said they received their medicines in a timely way. One person said, "Morning and night on time, yes, I know what they [tablets] are for."

Staff who administered medicines had been trained and their competencies assessed to ensure they were able to safely handle medicines. People's photographs were placed at the front of their medicine administration records (MARs) to allow easy identification and to reduce the risk of medicines errors. We looked through the MARs and medicines had generally been administered and recorded correctly with a low number of missed signatures. Some medicines were required to be given at specific intervals such as weekly or every three months. We saw clear information on the MAR showing when the medicines had been given and when these were next due.

We observed the nurse who administered medicines on the day of our inspection supported people with taking their medicines in a respectful and caring way, keeping them informed without being rushed. We saw they followed good practice guidance and were able to give an account of people's medicines and why each had been prescribed. MARs were signed only after the medicines had been seen to have been taken.

The majority of medicines were supplied in a monitored dosage system (MDS). Medicines not suitable to be supplied in the MDS were supplied in boxes or bottles. We saw most medicines were stored safely either in locked trolleys which were secured to walls, or in cupboards in the clinical room. Topical creams were stored in people's rooms. Records of the temperatures at which medicines were stored were recorded daily, including the medicine fridge. We found appropriate arrangements were in place for obtaining and disposal of medicines, with staff checking these on receipt into the home and storing them safely.

Some medicines were administered 'as required' (PRN). We saw PRN protocols were mostly in place and included the name, strength, dose and the reason the person had been prescribed the medicine. The MARs for PRN medicines included a space on the back for staff to record the reason the person had taken the medicine and the outcome. These had been completed appropriately.

We saw monthly audits of medicines were carried out and actions taken to address any discrepancies found. In addition, an outside agency carried out regular medicines audits and highlighted any areas for improvement. We looked at the most recent audit and saw the service had been found to be compliant in most areas. We carried out a random audit of medicines and found in most cases the amount tallied with the records shown on the MAR. In one person's record, the count was out by one tablet which the registered manager was able to provide an explanation for. Medicines were reviewed annually by the GP or where required.

People said they felt safe in the company of staff. One person said, "Safe? Yes, oh yes." Staff we spoke with had received training in safeguarding adults. They understood how to identify and act on allegations of abuse. Information on how to raise safeguarding alerts was displayed throughout the home and the registered manager discussed safeguarding with staff on a regular basis. We saw no recent safeguarding

incidents had occurred, however we felt assured that should an incident occur the correct processes would be followed.

People said staff took care when undertaking moving and handling tasks. One person said, "Oh yes, they (the staff) are always gentle and kind." Risk assessments were in place which covered areas of potential harm including falls, moving and handling, skin and nutrition. These were subject to regular review. Where significant risks were identified, risk reducing care plans were developed to protect people from harm. Where people had bed rails in situ, consent agreements were in place and risk assessments carried out. However some risk assessments needed making more specific to the exact combination of equipment used on each bed. We raised this with the registered manager who agreed to make the risk assessments more robust. We saw a bed rail audit was in the process of being undertaken as part of an overall assessment of the suitability of equipment within the home. We saw personal evacuation plans were in place in people's care records and staff were aware what level of support each person required in the event of an emergency evacuation

Incidents and accidents were recorded and investigated and measures put in place to reduce the risk of harm. Incidents were analysed monthly to look for any safety related themes or trends. We did not identify any concerning themes or trends.

There were enough staff deployed to ensure people received prompt care and regular supervision. Staffing levels were carefully thought out and were dependant on the needs of people living in the home. Shifts started at various times to fit in with the needs of people who used the service. Care and nursing staff were supported by ancillary staff including a laundry assistant, a cook, kitchen assistance, maintenance and an activities co-ordinator. The registered manager usually worked supernumerary but also provided nursing support to the registered nurse on shift. Most people we spoke with said there were enough staff and they were responded to in a prompt manner, for example. if they pressed the call buzzer. One person said, "There are always staff on hand," and a relative told us they thought the home had a strong reputation for generous staffing levels. However one person did tell us that they often had to wait too long for staff to take them to the toilet. Staff we spoke with all said there were always plenty of staff and enough to ensure people's care needs were met. This was confirmed by our observations of care and support. We saw staff had time to spend with people, chatting and supporting them, for example, encouraging them to drink plenty of fluids during the day. There was a low turnover of staff within the service and no outstanding vacancies with a very low use of agency staff. This allowed staff to get to know people well and develop the skills they needed to care for people.

Safe recruitment procedures were in place. We looked at two staff files. This showed the relevant documentation was present. Prospective staff completed an application form detailing their previous employment and qualifications. Candidates were required to attend an interview. However the service would benefit from recording interview conversations to provide a more robust account of recruitment decision making. Checks on people's backgrounds took place including ensuring a Disclosure and Barring Service (DBS) check and checking identity and references.

The premises was safely managed. The home was clean and hygienic with no offensive odours. Rooms were pleasantly decorated and well maintained. People were encouraged to personalise their rooms with their own possessions. Radiators were covered to help prevent burns and window openings restricted to reduce the risk of falls. We found water temperatures were appropriate in hot water outlets to ensure people had warm water whilst also protecting from the risk of burns.

There were adequate amounts of communal areas where people could spend time including five lounges

and large grounds. A dining room was available although it was not well used. We discussed with the manager how consideration should be given to improving the dining area so that it could be effectively utilised.

Regular checks were undertaken by the maintenance worker and external contractors. This included temperature checks of water outlets, and checks and maintenance of the fire, gas and electrical system. A fire risk assessment was in place. Whilst this was subject to annual review by the registered manager, it was several years since the original assessment was carried out, and would benefit from a complete re-assessment.

Equipment such as hoists was subject to regular testing and inspection and weighing scales were calibrated to ensure they remained accurate. Staff we spoke with said equipment was always kept in a good state of repair and maintenance or the registered manager would take action if any shortfalls were identified.

Good

Is the service effective?

Our findings

At the last inspection in February 2016 we rated the effective domain 'requires improvement'. This was because of concerns over the use of nutritional screening tools and inconsistencies in the provision of training updates. Overall, we found improvements had been made.

People said staff had the right skills and knowledge to care for them. One relative said, "They are very good with different clients." A person who used the service said of one staff member, "[Staff] is the best. [Staff] is very good, kind, knows what she is talking about." We saw there was a stable staff team with many staff members working at the home for a number of years. Two relatives complimented the service on its low turnover of staff. This allowed staff to develop good experience and knowledge of the people they were caring for. A health professional told us, "Laurel Mount is the one [home] where I have total confidence that the senior staff, especially [registered manager], know what is happening to all of their residents. Because there are just the three dedicated senior nurses (at least during my working week) it is easier for them to have that detailed knowledge."

Staff received a range of training relevant to their role. New staff received an induction to the service and ways of working so they knew how to carry out their role effectively. New staff without previous care experience were required to complete the Care Certificate. The Care Certificate is a set of standards for social care and health workers. It is designed to equip health and social care support workers with the knowledge and skills needed to provide safe and compassionate care. Staff were also supported to achieve further qualifications in health and social care such as NVQ's.

Training provision was a mixture of assessed workbooks and face to face training. This included subjects such as safeguarding, dementia, Mental Capacity Act (MCA), manual handling and fire. Staff received regular training updates from the registered manager during supervisions and more informal meetings. Specialist training was also provided in some areas such as catheter care, diabetes and wound care. Staff had a good understanding of the people and topics we asked them about, indicating training was effective.

Staff received regular supervision and appraisal. Although the notes from these were brief we could see staff development needs were assessed and discussions took place over training needs. An annual competency assessment was carried out on each staff member which looked at staff competence to deliver the role in areas such as nutrition and personal care and results from this this fed into their training needs assessments. We saw where shortfalls were identified these were addressed through staff meetings and used to inform training needs. Staff confirmed these checks took place.

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.

The registered manager had a good understanding of how to comply with the MCA.. We saw consideration had gone into which people required DoLS authorisations and appropriate applications had been made for those who lacked capacity and the provider suspected were being deprived of their liberty. There were currently no DoLS authorised with 11 applications pending assessment by the supervisory body.

Staff we spoke with had received MCA/DoLS training. Staff all had a good understanding of the current status of DoLS authorisations within the home, that none had been authorised but 11 were awaiting assessment. This showed us staff were aware of the DoLS process.

Where people had capacity we saw they consented to their care and support plans. We saw evidence the service was acting within the legal framework of the Mental Capacity Act. Capacity assessments had been carried out and we saw evidence decisions had been made in people's best interests such as around the need for flu vaccinations and bed rails. We did find one capacity assessment located in each person's care records was not related to a particular decision. We reminded the registered manager that capacity assessments must be specific to a particular decision.

We saw people were supported to consume a varied and nutritious diet. People's weights were recorded monthly or more frequently if of concern. Where people were assessed at risk nutritionally or at risk of choking, referrals had been made to the SALT team. Nutritional assessment tools were completed in people's care records with actions taken. For example, one person had been seen to lose weight and the service referred to the GP who prescribed a nutritional supplement. We saw since the supplement had been given the person had regained the lost weight. Supplements were in place appropriately and corresponded to the information in people's care records. Staff we spoke with were able to tell us the correct amount of supplements each person should be given.

We spoke with the chef and the kitchen assistant who were very knowledgeable about people's dietary needs, including which people were on a special diet, such as a diabetic diet. We saw a file containing dietary needs, likes and dislikes for each person living at the home as well as a copy of the SALT assessment. They explained how they used full fat milk, cream and butter to increase calorific content of the food as well as using sweeteners in diabetic cooking. For example, they explained when making custard, they would make this unsweetened and then split the product into diabetic and non-diabetic needs, sweetening one with sugar and the other with artificial sweeteners. They showed us a tray of freshly baked buns and cakes, indicating the ones baked with sweetener for diabetics. This meant the service accommodated people's dietary needs when planning menus.

On the day of our inspection, we saw people were offered a choice of cereal, toast, fruit juice and hot drinks at breakfast time, with a cooked breakfast if they wanted. At lunchtime, the chef prepared freshly battered fish, chips and mushy peas which we saw people enjoyed, followed by fruit and ice cream. The teatime menu consisted of soup, sandwiches and a dessert of bread and butter pudding and custard. The chef told us the food was mostly home-made and they would offer an alternative if people did not want what was on the menu. We saw people were offered hot drinks and snacks though out the day including milk shakes for those requiring extra nutritional content. Some people had their own mugs and one person was provided

with their own bone china tea cup and saucer since this was their preference. People generally spoke positive about the food provided. One person said, "It's very good." Another person said, "You don't get a choice but what you get is nice." Although there was one option on the lunchtime menu staff were clear they would make an alternative if people did not like what was on offer. The menu and our observations demonstrated the home provided a good range of food and drink that met people's individual needs.

We observed the mealtime routine and saw people ate at their own small tables in the lounge areas rather than in the dining room. This reduced the opportunity for social interaction and meant some people were sitting in the same area all day. We spoke with the registered manager who explained they had tried various options in the past but people were not keen on using the dining room. They said the layout of the dining room was not ideal at present since the tables were too large. They told us they were looking into another lounge being utilised with smaller tables to create a more inclusive experience. We concluded this would be of benefit to increase people's social interaction and mobility. We saw staff assisted people with their meals where required, sitting next to them and offering gentle encouragement in an appropriate manner.

People's healthcare needs were met and the service achieved this by developing appropriate plans of care and working with a range of health care professionals including GPs, the community matron, specialist nurses, dieticians, opticians, dentists and podiatrists. This was confirmed by people and their relatives. We saw many people had expressed wishes in their care plan to remain out of hospital wherever possible and the service supported this. For example, we overheard one of the senior staff speaking to a person's GP on the telephone. They insisted the GP visit rather than the person attend hospital since the person and their relative had stated they did not want hospital admissions. We saw the GP visited later that day which meant the person's wishes had been respected.

We made contact with three health professionals who provided very positive feedback about the quality of the service provided at Laurel Mount. One health professional said, "I have always found management and staff to be efficient, compliant, professional, caring, understanding and very receptive to all help and support on offer." Another professional told us, "The nurses in charge are always willing to follow up the needs of the patients and contact me if there are any concerns. I find this multidisciplinary way of working very valuable, both for the patients and the health professionals involved as I feel we all learn valuable information from one another." A third professional said, "I believe Laurel Mount offers a safe, effective service, which above all, is caring and respectful."

Good

Is the service caring?

Our findings

People and relatives we spoke with all said the home was a homely and caring environment. They said staff treated people well and delivered care in a friendly and compassionate way. One person said, "They are incredibly kind," and another person commented, "Yes, very kind." A third said, "Yes, they are good; most of 'em. They're not disrespectful." One relative said, "There is a constant level of kindness. Staff will often have a little joke or a little word," and another relative said, "Always very caring." A third relative told us, "On a personal level, staff are caring. I've never heard a cross word from staff. Staff want to be helpful. They develop a personal relationship with people."

Health professionals also provided positive feedback about the friendly and kind atmosphere within the home. One told us, "Laurel Mount has always been very welcoming, clean and a calming environment," and another told us, "I have always found the staff to be very friendly, helpful and willing to assist me as required." A third professional said, "All the staff seem to have a friendly relaxed attitude which the residents appreciate."

We observed care and support and found staff treated people well and ensured people's dignity and privacy was respected. For example, we saw staff knocked on people's doors and asked permission before entering. Staff respected people's need for privacy during toileting. We saw staff were gentle, compassionate and caring in their approach to people and spent time sitting and talking with people. We saw one staff member kneeling by one person's side and quietly chatting about how they were feeling. The person told them they weren't feeling well and the staff member responded with sympathy, trying to find out what was the problem. Staff approached people calmly and with warmth and people responded in similar manner.

Good positive relationships had developed between people and staff due to the low turnover of staff. Staff knew people well and their individual likes, dislikes and preferences. We saw this information was recorded within care and support plans and people's life histories had been sought to assist staff better understand people. Staffing levels allowed staff the time to sit and chat with people as well as delivering care and support. We saw ancillary staff such as the maintenance worker, laundry worker as well as the registered manager spent time with people, meeting their social and emotional needs. This made for a friendly, person centred and inclusive atmosphere within the home.

We saw people were encouraged to maintain their independence, for example, staff encouraged people to use the toilet and eat independently if they were able. Plate guards and clothing protectors were used to help people be more independent at meal times. Two relatives told us how they were impressed by the effort taken by staff to ensure their relatives did not spend all day in bed and assisted them to get up to ensure they spent time with others in the home.

Communication care plans were in place. These demonstrated the service had taken the time to understand how people preferred to communicate including measures to reduce distress. For example, one person's records showed that following a bereavement their communication care plan had been re-written to aim to increase interaction and stimulation to help with the grief.

We saw visitors were welcomed and staff had time to chat to people about any concerns they had. We saw this had been highlighted at the most recent survey, where relative responses included, 'I feel I am made most welcome at all times,' and, 'Laurel Mount staff have always been particularly helpful and pleasant with me.'

Religion or belief is one of the protected characteristics set out in the Equalities Act 2010. Other protected characteristics are age, disability, gender, gender reassignment, marital status, pregnancy and maternity status and race. We saw the service had organised visits and services from various faith groups, dependant on the needs and requests of people living at the home.

People and relatives said they felt listened to by the service and choices were respected. One relative said, "He goes down when he wants to, it's his choice." We saw staff listened to people and offered them choices about what they wanted to do, where they wanted to sit and what they wanted to eat. Discussions with people and relatives were recorded in care plans showing people's opinions regarding care and support had been listened to. The registered manager gave us an example of how one person had wanted to attend a funeral and had arranged a local taxi and companion service which meant the person was able to attend safely. This showed care and thought had gone into ensuring the person's wishes were respected.

End of life care planning was in place. We saw the service sought to understand people's preferences at the end of their life. One relative told us that when their relative had been admitted to the home they had a detailed end of life discussion with the registered manager to ensure the person's advanced wishes were met. They told us they were impressed with how accommodating the registered manager had been to ensure this was adhered to.

Good

Is the service responsive?

Our findings

At the last inspection in February 2016 we rated the responsive domain 'requires improvement'. This was because of concerns over the lack of content to some care plans. We found improvements had been made.

People, relatives and health professionals said the service provided good, person centred and responsive care. One relative said, "[Relative] has noticeably improved since [person] came here; [person's] mobility has improved since [person] came here. Over time they (the staff) get to know each resident and they look for the next thing to improve. It was lovely that [person] came here." Another relative told us, "They (staff) are very sensible and practical, they sort things out. They are very positive, very responsive." A health professional told us how the home provided good quality care and had managed to settle people into the home who had been too challenging for other homes due to behaviours that challenge.

Since the last inspection we saw improvements had been made to care plans to ensure they contained detailed and person centred information on people's individual needs. People's needs were assessed prior to admission by the registered manager and a pre-assessment of needs document completed to help ensure the home could meet people's needs as soon as they entered the home. Care records contained clear information which documented individual people's needs and how to provide care and support. This reflected a person centred approach. Care records were easy to navigate although some handwriting was difficult to decipher. The registered manager told us they were considering introducing printed care plans which would be easier to read. Staff demonstrated a good understanding of people's individual needs and how to ensure appropriate care. This evidence gave us assurance that care plans were followed.

People looked clean, appropriately dressed with neat and tidy hair. This indicated their personal care needs were met by the service. Where people had specialist mattresses in place, we saw these were set at the correct weight and information about mattress settings was attached to the mattress blower box to ensure the mattress was at the correct setting. We saw the registered manager had highlighted any concerns with specialist mattresses during the mattress audit and these were passed to the maintenance person for action, or new mattresses/parts were ordered. Where people required specialist equipment such as pressure relieving cushions on their seating, we saw care plans were followed to reduce the risk. There were no pressure sores within the home and there was a low instance historically.

Care plans were subject to regular review and changes made when people's needs made. We saw people's and their relatives' comments were recorded to show they had been consulted and involved in care and support planning. Relatives said communication was good and they were informed if there was a change in their relative's condition. A relative said, "Updates and communications are good."

Overall people and relatives praised the activities and social opportunities in the home. One person said, "[Activities coordinator] is great; just the right one for the job." Another person told us how there were lots of activities such as games and puzzles. However two people felt the provision of activities could be improved at times. Relatives spoke positively about how the service had regard for social aspects of care and acted to avoid social isolation by encouraging their relatives to sit in communal areas. Another relative whose

relative spent large amounts of time in bed said, "Staff will sit and talk to [person]." An activities co-ordinator was employed who worked 30 hours a week, with care staff encouraged to lead activities in their absence.

We saw activity sheets were present in most people's care records which highlighted what activities they had taken part in. The registered manager told us the activities co-ordinator was compiling a document to be included in people's care records. This would detail information such as likes, dislikes, what specific toiletries they used and any extra details about the person; for example, if they enjoyed a sherry at lunchtime. This would mean a more complete picture of the person could be obtained to allow better knowledge and for activities to be more meaningful and person centred.

A list of available activities was displayed within the home and the registered manager told us this was flexible dependant on what people wanted to do on any particular day, rather than a set routine. We saw in people's care records activities such as gardening, games, flower arranging, quizzes, reminiscence and 'touch and feel' sessions had taken place. During our inspection we saw staff reminiscing with people on a one to one and small group basis. A hairdresser also came to the home weekly or as required and we saw a musical entertainer came fortnightly. Staff took some people out on an individual basis, although there were no planned group trips out.

A newsletter was produced four times a year and updated families on events occurring within the service. In the latest issue we saw with the consent of one person, their life story had been made into a newspaper article. This was a good way to involve people in the creation of the newsletter and help others to understand the person's life experiences.

People and relatives said they were very satisfied with the care and support provided and that minor issues were quickly dealt with by the registered manager in a positive way. One relative said, "[Registered manager] sorts problems out." A complaints policy was on display within the home. We saw the service had not received any complaints for a considerable amount of time. We spoke with one relative who had expressed a concern about a prescribed medicine but they told us this had not been a complaint about the service and the registered manager had dealt with this in a supportive and understanding manner and their worries had been alleviated. The provider showed us the system they had in place for recording complaints and minor concerns which gave us confidence any issues would be taken seriously and appropriately investigated. We saw a number of compliments had been received, mainly in the form of cards from relatives and these were stored in a compliments file.

Good

Is the service well-led?

Our findings

An experienced registered manager was in place who we found to be dedicated to providing high quality care. We found all required notifications had been submitted to the Commission. This helped us monitor events occurring within the service.

People and relatives praised the overall quality of the service and how it was managed. One person said, "It's lovely. This beats the other homes I've been in." Relatives' comments included, "All fine. I'm here a lot, I'm regular, never had any issues", "It's a bit like family run; we all get on", "Really pleased, highly recommend," and of the leadership, a relative told us, "They are pretty responsive. Little things get fixed." We asked relatives whether the staff team worked well together. They said it did. One relative said, "I think so. I've never seen anything other than professionalism."

People and relatives specifically praised the registered manager saying they were approachable and listened to them. One relative said, "[Registered manager] is particularly good. She knows what's effective, she's a good organiser." A healthcare professional said, "I would like to say that in particular the manager is a pleasure to deal with at all times. [Registered Manager] doesn't hesitate to contact me if she requires advice and support."

Staff we spoke with praised the registered manager and told us they felt supported and would be happy to approach them with any concerns. We saw the registered manager was a visible presence within the service, knew people by name and led the staff team by example. Staff told us they all worked together as a team and enjoyed their roles. One senior staff member told us, "I like being hands on, communicating with people and transferring it to the care records. You make a difference to their lives. It's a very happy, informal place. You hear a lot of laughter here. [Registered manager] is very good at listening; very empathetic. It's a very rewarding job." A care worker also commented, "I love my job. This one's homely (talking about the service). There's a lot of interacting with the residents. Staff are all lovely; help each other out. I definitely feel supported." Staff told us they would and had recommended Laurel Mount as a place to work and as a place for someone to live. A number of staff told us they had or used to have relatives living at the home.

We found the manager was dedicated to ensuring continuous improvement of the service. We saw they reviewed other CQC inspection reports to identify common shortfalls in similar services. We saw evidence this had been a useful mechanism for making improvements to the service. We felt assured by the commitment of the registered manager that any issues we identified during the inspection would be promptly addressed in keeping with a service that was well led and managed.

Systems were in place to assess and monitor the quality of the service. Audits took place in areas such as medication, incidents & accidents, infection control, equipment and weights. We saw evidence these had been effective in identifying and rectifying issues. Information on a number of quality indicators was submitted to the local authority on a three monthly basis as part of a system to monitor quality. External expertise was sought in some areas as part of a system to ensure continuous improvement of the service. For example, medication audits had been carried out by a pharmacy to provide specialist expertise in the

area of medicines management and an external consultant had also completed an overall care quality audit which had produced an action plan which the registered manger was working through.

We asked if the service held meetings for staff. The registered manager told us they held regular informal meetings but did not document these. Staff we spoke with confirmed meetings were held but were on a one-to-one or small group basis. They also told us they felt informed about what was happening in the service and their voice was listened to. We spoke with the registered manager about the need to document meetings to provide an audit trail of discussions so all parties were clear of the actions going forward in keeping with good governance principals.

Staff completed an annual satisfaction survey which was collated and actions taken if required. For example, we reviewed the results from the last survey, completed at the end of 2016 and saw staff satisfaction was good. However, out of 13 responses, five commented they had not received regular supervision and two had not received an annual appraisal. We saw a matrix had been put in place to plan and implement these over the coming year.

We saw the registered manager had an 'open door' policy so any relatives, staff or people living at the home could approach them about concerns at any time rather than hold formal meetings. The service sent out an annual survey to people/relatives/health care professionals to gauge satisfaction. We looked at the most recent results which had been collated and showed a high degree of satisfaction. Comments included, 'The dedication and commitment of staff is apparent in the home and [relative] is always clean and tidy', 'They look after [relative] in a dignified and happy way,' and, 'Senior members of staff are always available.' This matched the feedback we received about the service from these stakeholders, providing assurance that a high quality service was provided.