Methodist Homes

# Laurel Court (Didsbury)

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

This inspection took place on 9 and 14 January 2019. The first day of inspection was unannounced. We carried out this inspection to see if the provider was meeting all legal requirements.

Laurel Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

We last inspected Laurel Court (Didsbury) in October 2017 when we rated the home requires improvement overall. We identified three breaches of the regulations in relation to managing risks to people, providing adequate numbers of staff and good governance. Following the last inspection we asked the provider for an action plan to tell us how they would make improvements to meet the requirements of the regulations. We found the provider had followed their action plan and was now meeting the requirements in relation to these breaches.

Laurel Court is a purpose-built care home situated in the Withington area of Manchester. Accommodation for people is provided in a number of 'households' situated over three floors, with a further floor with rooms for training, staff use and storage. The home provides both residential and nursing care to older people and people who are living with dementia. The care home accommodates up to 91 people and at the time of this inspection the home was providing care and support for 86 people.

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. At the time of this inspection there was a registered manager in post at Laurel Court.

Person centred care plans and risk assessments were in place. These provided guidance and information about people's support needs, their likes, dislikes and preferences and how to mitigate any identified risks. Staff we spoke with knew people and their needs well.

The home had effective systems for ensuring concerns about people's safety were managed appropriately. A safe recruitment process was in place. Staff completed a thorough induction programme and regular checks were made on their development, knowledge and performance.

The service was working within the principles of the Mental Capacity Act (2005). A capacity assessment tool was used and applications made for a Deprivation of Liberty Safeguard (DoLS) if a person lacked capacity. The Care Quality Commission were informed of any authorisations granted.

New menus had been introduced but if people did not like the meals on offer alternatives were available via a snack menu. Kitchen staff were informed of people's dietary needs and menus were shaped based on

people's preferences and choices. Residents were allowed time to eat at their own pace or received assistance and encouragement from members of staff.

An activities programme was in place. The activity coordinators carried out group activities and sessions but also devoted time for individuals who preferred one to one activities or going out in the community. People's cultural and religious needs were being met by the service, with access to a chaplain on site.

There were policies and procedures in place around respecting equality and diversity, so that people were treated equally. People told us they felt included and not discriminated against.

The home was responsive to changes in people's needs and any changes were documented following scheduled reviews of care or following an incident. Relatives were kept up to date with information regarding their family member.

Laurel Court had a complaints policy in place. Issues raised verbally had been recorded and responded to.

We received positive feedback about the leadership and management within the home from staff, people who used the service and their relatives. There were robust audit systems in place to monitor accidents, incidents or safeguarding concerns within the home. Coaching sessions had been introduced to bridge identified knowledge gaps in aspects of care.

The Manager had introduced 'champion' roles and staff had voluntarily signed up for those that were of interest to them or because they had specialist knowledge. The service worked in partnership with other agencies including health professionals, local authority representatives and volunteers.

## 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

Care records contained specific risk assessments and staff understood how to support people to minimise risks from occurring.

Systems in place for the receipt, storage and administration of medicines were robust and kept people safe.

Required safety and maintenance checks were being carried out at regular intervals to maintain the safety of people living in the home.

### Is the service effective?

Good

Staff had opportunities to meet with their manager to discuss their work, performance and training and development needs.

Staff gained consent from people before carrying out care.

The service was effective in responding to deteriorations in people's health and involved other professionals in reviews of care.

### Is the service caring?

Good

Care plans detailed how people liked to receive their care and specified likes and dislikes.

Staff demonstrated knowledge of dignity and privacy issues and gave examples of how they respected people's rights and wishes

People were encouraged to do things independently if it was safe to do so.

### Is the service responsive?

Good

The care planning process was person centred and focused on the person as an individual.

Care plans and risk assessments were reviewed on a regular basis to ensure the information was up to date.

The home supported and promoted people to maintain their faith if they wished to do so.

## Is the service well-led?

Good

There were robust audit systems in place to monitor accidents, incidents or safeguarding concerns within the home.

The company used various ways to obtain feedback from people using the service and their relatives so that the service could continuously improve.

Ways of improving practice were communicated to staff to enhance the quality of care.

# Laurel Court (Didsbury)

**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 9 and 14 January 2019 and the first day of inspection was unannounced. This meant the people who lived at Laurel Court and the staff who worked there did not know we were coming. The inspection team consisted of one adult social care inspector, a bank inspector and an expert by experience on the first day of inspection and one adult social care inspector on the second day of inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information that we held about the service, including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We contacted the local Healthwatch organisation and the local authority commissioning team to obtain their views about the provider. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. No concerns were raised about the service provided at Laurel Court nursing home.

We spoke with twelve people who used the service, two relatives, a visitor and 13 members of staff, including the registered manger, the area manager, a nurse, two senior staff, four care workers, a music therapist, activities coordinator, maintenance and domestic staff and the cook.

Some people who used the service were unable to tell us about their care therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who cannot tell us about their care. We observed care and support at lunch time in the dining room and also looked at the kitchen, the laundry and a number of people's bedrooms. We saw the outside spaces available for people using the service.

We reviewed eight people's care records in detail. We looked at five staff recruitment files and records in relation to staff training, supervisions and appraisals.  Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members.

Good

# Is the service safe?

## Our findings

People told us they felt safe living at Laurel Court. Residents who lived at Laurel Court appeared relaxed and comfortable in the company of staff. When asked if they felt safe people told us, "The way the staff have looked after me has given me a lot of reassurance about being here"; and "It is a nice place to be in; I do feel safe." Two relatives and a visitor we spoke told us that that they were happy with the care provided and had no concern of safety issues for their family members.

People we spoke with told us there were enough staff available when they needed help and support and added that staff responded to their needs. One person told us, "Staff usually respond to my bells quickly," but accepted delays in receiving assistance were sometimes unavoidable. We also spoke to people who preferred to stay in their rooms and they considered there were enough staff. They told us that staff checked on them at regular intervals during the day to make sure they were safe and to bring them meals and drinks. Rotas we saw confirmed that sufficient staff were deployed to meet the assessed needs of the people using the service. We judged that people could expect consistency from a group of staff who understood their care and support needs.

Risks to people's individual health and wellbeing were being assessed to enable them to remain safe. Care plans contained individual risk assessments including assessments for; mobility, pressure care, in and around the home, out in the community and personal care. Each plan explained how to manage these risks to ensure that people received the care they needed in a safe way. Staff were able to demonstrate that they understood how to support people to minimise risks from occurring. We observed staff following the guidance in people's care plans, for example ensuring that one person was seated before handing them a drink.

Robust recruitment processes remained in place to ensure staff were suitable to work with people before they started. Pre-employment checks were carried out; these included obtaining a full employment history, identification checks, references from previous employers and Disclosure and Barring Service (DBS) checks. A DBS check helps employers to identify people who are unsuitable to work with vulnerable adults in care settings. This meant that people who used the service could be confident that staff appointed were suitable to work with vulnerable people.

The home had effective systems for ensuring concerns about people's safety were managed appropriately. Records showed potential safeguarding concerns had been reported promptly to other agencies such as the local authority and The Care Quality Commission (CQC). Staff were familiar with safeguarding processes, they attended regular training. They had confidence in the registered manager who they thought would be receptive to hearing and acting upon any concerns they might raise. They also knew of other agencies they could contact if they did not feel appropriate action had been taken.

During our visit we looked at the systems that were in place for the receipt, storage and administration of medicines and found these to be accurate. Reviews of medicines were carried out by health professionals and any individual health concerns as identified by the home were dealt with. People's medicines were

reviewed in a timely manner and people were treated quickly when the service identified the start of any potential illnesses.

Each person had a photograph at the front of their medicine administration record (MAR). We observed staff dispensing medicines during the inspection. We saw that staff responsible for administering medicines had regular competency checks and observed practices were carried out by senior management. The service had implemented improved processes to reduce the likelihood of medicine errors. This meant that medicines were administered safely and people using the service were not placed at risk. The service demonstrated people were receiving their medicines in line with their doctor's instructions and from appropriately trained staff. Those who required more encouragement and support with medicines received it.

Systems were in place to prevent and control the risk of infection. Housekeeping staff were employed and followed a schedule of cleaning each day. The service was clean and smelt fresh during our inspection. All staff completed infection control training and followed the provider's policy and procedure. There were regular audits of the cleaning cupboards and laundry. The manager also completed a regular infection control audit.

Required safety and maintenance checks were being carried out at regular intervals to maintain the safety of people living in the home. Two new lifts had been installed since our last inspection and the required service and maintenance regimes were in place. The cleaning regimes to water systems and facilities required to ensure people were protected from the possibility of legionella were being carried out by an approved company.

Good

# Is the service effective?

## Our findings

People's needs were assessed and their care was planned to ensure their needs were met. Care records had clear guidance for staff on how to support people with their needs in the way they wanted. Care plans and risk assessments described how to support people. Staff had received training regarding behaviours that challenged the service and followed guidance, informing them of proactive and reactive strategies to support people. There was good use of nationally recognised assessment and management tools, including tools for pressure wounds, pain management and wound care. These were kept under continuous review to ensure they met people's needs.

The registered manager, along with unit managers, checked how staff were performing through one to one supervisions and an annual appraisal of staff's work performance. Staff confirmed that they had opportunities to meet with their manager to discuss their work, performance and training and development needs.

Staff had the skills, knowledge and experience to deliver effective care and support. Staff told us they had received an induction, on-going training, competency assessment, supervision and where required appraisals. There was a rolling programme of training to meet people's needs including any specialist needs. We checked to see if nurses were supported to maintain their registration with the Nursing and Midwifery Council (NMC) and saw that they were.

We received mixed feedback about the food on offer at the home. Some people we spoke with were complimentary and described the meals as 'Very good', 'Excellent food' and 'Delicious'. Other people we spoke with considered food had been 'Poor'.  Residents were consulted about menus during residents' meetings and the chef told us that any comments were taken into account when planning menus. Due to the negative comments about the food and in response to requests from residents, the home had introduced a new set of menus the week of this inspection.

We saw information was available for the chef and kept in the kitchen in relation to the consistency of food for people and we spoke with the chef who told us about the special diets catered for, for example diabetic and low-fat diets. We saw that menus were in place and these were altered if the chef thought it appropriate. If people did not like the meals on offer alternatives were available via a snack menu. We were assured kitchen staff were informed of people's dietary needs and menus were shaped based on people's preferences and choices. We observed lunch time meals on both days of inspection and saw that the food was home cooked and looked appetising. Residents were allowed time to eat at their own pace or received assistance and encouragement from members of staff.

We saw staff offered people a choice of drinks with their meal and throughout the day and staff were monitoring and recording people's fluid and food intake where it had been identified that the person was at risk of dehydration or malnutrition. Care records we saw showed that people's nutritional needs were assessed and monitored to ensure their wellbeing.

People's care records showed that their day to day health needs were being met. People had access to a GP and district nurses visited the residential service on a regular basis to undertake routine treatments. The home had a good relationship with health professionals and we judged that the service was effective in responding to deteriorations in people's health and involved other professionals in reviews of care.

We toured the building during the inspection and visited all communal areas. The home was well decorated and each floor made good use of the space with small seating areas as well as larger lounges.

Each resident had their own bedroom with en-suite facilities. Bedrooms we visited had been personalised to people's tastes. We saw people had family photographs, personal furniture and ornaments to help the room feel homely. There were two new lifts to access the upper floors and we saw hand rails on the corridors to help people to move independently. There were hoists, slings and other items of equipment, for example walking frames and wheelchairs, to help people to mobilise around the home. Staff told us they had been trained to use all equipment.

Good

# Is the service caring?

## Our findings

There was a nice, relaxed atmosphere in all areas of the home. We spent time observing people in the lounges and dining areas of the home and both watched and heard activities that were going on. We observed staff treating people affectionately and heard staff speaking in a friendly manner. Staff displayed respect and admiration for people using the service and we saw that trusting relationships had formed.

People were comfortable with staff and easy in their interactions. People were pleasant and smiling; they were alert and engaged in what was happening around them. Conversations we overheard between staff and people demonstrated a level of mutual respect and affection, with staff asking people for their preferences and engaging in shared laughter at situations.

On occasion a person could become distressed. If this escalated staff showed understanding and knew the strategies to diffuse this behaviour, dealing with people in a kind and compassionate manner. Staff respected people's decisions to decline support and reoffered this at different times during the day. Staff gave people space and time to do things for themselves but were on hand to provide support when needed.

Staff we spoke with were able to tell us about each person's needs, likes, dislikes and how they liked to be supported.  Staff's knowledge and understanding of each person living at the home helped ensure they could both listen to and communicate effectively with people. We observed care interactions that were kind, and sensitive. People's privacy and dignity needs were understood and respected. Staff were observed knocking on bedroom doors and waiting for a response before entering.

Care workers sought consent from people where possible before undertaking care tasks and were kind and caring in their approach. We saw examples of this during our lunch time observations. We heard care workers assisting people telling them what the food on offer was and asking their preference. Residents who wanted to eat independently did so, whilst staff sensitively supported others to eat their meals. People weren't rushed. We saw that staff were patient in their approach and checked that people were ready to continue with eating.

Staff understood the importance of promoting people's independence and encouraged people to do as much for themselves as possible. We observed appropriate moving and handling interactions when staff were assisting residents to move to different areas of the home. People were kept informed and were reassured when being assisted to move using equipment, such as a hoist.

The provider was aware of the importance of ensuring equality, diversity and people's human rights were upheld and incorporated this into staff training. There were policies and procedures in place to assist in meeting this requirement. The activity coordinator described to us the ways that they interacted with people who preferred to spend time in their rooms or outside, taking them out for a coffee in the community, to the gym or to church. Staff were caring in their approach and tried to ensure people did not feel excluded. People told us they felt included and we judged that the care provided to people living at Laurel Court was not discriminatory.

Good

# Is the service responsive?

## Our findings

People received a person-centred service that was responsive to their needs. Person-centred care indicates care is specific to the individual concerned. The provider used person-centred plans to support and involve people to make decisions about their care and their lives overall.
One person we spoke to told us, "I can have a say in my care and I have asked questions in meetings." This confirmed that people and their relatives were involved in the planning and delivery of the care and support they required.

We found that staff had prepared a care plan for each person. These described the care each person needed and had agreed to receive. They provided staff with a range of personal information and people's preferred daily routine, what they could do for themselves and what support they needed from staff. The care plans covered different aspects of each person's care needs. Records indicated that people and their relatives were involved in their care and any decisions made. Care plans were individualised and gave guidance for the nurses and care staff to follow; enabling them to meet people's needs. For example, information to promote people's skin integrity including, monitoring checks, pressure relieving equipment and repositioning schedules. People who had specific dietary needs had detailed risk assessments and care plans to ensure their needs would be met.

Staff were kept updated about any changes to people's needs or health at daily handovers and staff completed daily reports about people's wellbeing during the day and night. A diary and communication book helped ensure that important information was passed between staff, or that appointments people needed to be supported with were not missed.

Staff were able to describe in detail peoples routines and preferences and showed that they knew people well. Staff were able to provide some additional information they knew about a person's support needs or areas they needed prompting with. For example, staff understood a person who needed prompting to recognise their washing equipment but knew what to do with it once they were pointed out.

We saw that people were referred to Speech and Language Therapy (SALT) or to the dietician where required, and the advice and recommendations made were incorporated into people's care plans.

People's care plans and risk assessments were reviewed on a regular basis to ensure the information was up to date and continued to inform staff how to meet their needs. We were confident that the home was responsive to changes in people's needs and could see these documented following scheduled reviews of care or following a particular incident, such as a fall. This demonstrated that the service responded to changing needs and made referrals to relevant health professionals to ensure people's safety and wellbeing. Relatives we spoke with expressed no concerns regarding the support provided and said they were always kept up to date with information regarding their family member.

Staff knew the people they were supporting very well. We heard throughout the inspection examples of people being given, and making, choices about their daily lives and the support they received. Staff were

aware of their role and responsibilities and were able to describe the needs of individuals who used the service. During informal conversations, staff spoke about individual residents with knowledge of their backgrounds, likes and dislikes, as well as their current individual needs and behaviours. We saw examples of people being able to express their individual personalities, for example in the way they presented themselves and in what they chose to wear. Staff demonstrated to us knowledge of an individual and gave us examples of how they respected people's rights and wishes.

An activities programme was in place. Two activity coordinators carried out group activities and sessions but also devoted time for individuals who preferred one to one activities or going out in the community. The provider also employed music therapists to visit Laurel Court and other homes in the group. We met with the music therapist who was on site during our inspection. We were able to observe a musical session taking place and saw how people benefitted from these sessions, playing instruments, laughing and singing along with staff. We were able to evidence the difference that music had made to people living at Laurel Court and the positive outcomes achieved by individuals as a result of taking part in music therapy.

The home had also made links with the community, accompanying people to church and various social groups including a local tea dance and a café. Students in the area visited the home to listen to people talking about their memories. There was a photography club, art group and poetry readings and the latest project involved making a Punch and Judy type theatre, covered in photographs of Hollywood stars. Following a donation made to the home puppets had also been purchased. People and their relatives we spoke with considered there was plenty of entertainment and enough going on for people to get involved with. One relative told us, "The home's improved in every aspect. The care is second to none too."

We asked the manager how the service met people's spiritual needs. The home had access to a chaplain who was fully involved in the daily life of the home and available for all denominations of faith. People we spoke with appreciated this and those who wanted to maintain their faith were able to do so. This meant that religious needs were met if this aspect was important to people.

Complaints were logged and dealt with according to company timescales and management saw these as an opportunity to improve the service. The home had a complaints policy that was displayed in the entrance lobby to the home. Most people we spoke with told us they had not raised any complaints and did not feel the need to do so. We were assured that people using the service and their relatives felt comfortable with all levels of management in the company. If they felt it necessary to make a complaint they were confident that this would be addressed.

The home cared for people approaching the end of life and that support was extended to relatives and other visitors to the home. A member of staff had  been nominated for a national care award in 2018 due to going the extra mile whilst caring for a person approaching the end of their life.

Good

# Is the service well-led?

## Our findings

The manager had been in post since May 2018 and had applied to the Care Quality Commission (CQC) to become the registered manager. The manager had subsequently been registered on 27 November 2018.

The manager spoke passionately about providing people with a quality service and ensuring the care that was being delivered was up to date and followed best practice guidance. The manager was a nurse who kept their clinical knowledge by continuous personal development. The registered manager was supported by a deputy manager, a team of nurses and care staff. Additional support was provided by a network of other managers in the region, an area support manager, who was present on the days of inspection, a quality business partner and specialist trainers employed by the company.

In conversation with the registered manager it was evident that they understood their managerial responsibilities. The registered manager was knowledgeable about the legal requirements of The Health and Social Care Act 2008 and informed CQC about notifiable incidents, as is the law. We checked to see if the rating was displayed in the home and found that it was prominently displayed in the foyer and on the provider's website, meeting the legal requirement.

At our last inspection we judged that audit processes were not robust enough as the registered manager had not addressed the shortfalls in the service regarding assessment of risk and staffing levels. At this inspection we found that things had improved and the service was now compliant in these areas.

There were robust audit systems in place to monitor accidents, incidents or safeguarding concerns within the home. Statistics for these were communicated in weekly reports to head office where further analysis took place if warranted. Other audits undertaken by the registered manager or delegated to senior staff included those on care plans, medicines, the meal time experience and housekeeping spot checks.

A recent quality audit carried out in December 2018 had identified areas for improvement, such as medicines, staffing and recruitment and the environment. The registered manager had devised an action plan to enable the management team to achieve the maximum score in all aspects at the next quality audit. Coaching sessions had been introduced to bridge identified knowledge gaps in subjects such as nutrition and hydration, medicines safety and the safe use of bed rails.

The Manager had introduced 'champion' roles and staff had voluntarily signed up for those that were of interest to them or because they had specialist knowledge. Champion roles included areas of care such as dementia, end of life, medicines and infection control. Being a 'champion' involved undertaking additional training, sharing knowledge, new practices and offering advice to other colleagues. Staff we spoke to these 'champion' roles were eager to learn and felt fully supported by the registered manager.

The company used various ways to obtain feedback from people using the service and their relatives so that the service could look to improve. Independent surveys were undertaken on behalf of the service and we saw positive feedback from people using the service and their relatives. We received positive feedback about

the leadership and management within the home from staff, people who used the service and their relatives.

Responses from surveys of people their relatives and staff were analysed. We saw regular resident and relative meetings were held and people's opinions sought. The home was open and transparent and shared results of any audits, inspections and surveys on resident notice boards located on each floor of the home.

Ways of improving practice were communicated to staff by the registered manager and other senior staff in a number of ways, for example in staff meetings, during observations and supervisions. This meant that staff were made fully aware of their responsibilities and company expectations. Staff understood the management structure and who they were accountable to. Staff said they understood their role and responsibilities and said this was also outlined in their job description and contract of employment.

The registered manager was looking at ways to continually improve the service, even though the feedback we received was positive. We saw numerous examples of how the service worked in partnership with other agencies including health professionals, local authority representatives and volunteers. Policies and procedures were in place and made available to staff on induction and throughout their employment.