

Methodist Homes Lauriston

Inspection report

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Date of inspection visit:
08 May 2019
09 May 2019

Date of publication:
06 June 2019

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service:

Lauriston is a purpose built, fully adapted service registered to accommodate up to 60 people who require nursing or personal care. The service specialises in providing nursing care to older people with age related conditions, including dementia. The service is divided into four units spread over two floors, with access to the upper floor via stairs and a lift. There is a car park to the front of the building and gardens to the rear. There were 53 people living at the home at the time of the inspection.

People's experience of using this service:

The providers' governance systems had not consistently identified the shortfalls found at this inspection. There was a lack of clear and accurate records regarding some people's care and support. For example, wound care and pressure care management. The management of behaviours that challenge were not always documented clearly and lacked details to manage them effectively. The leadership within the service had been impacted on by the fact that there had been no registered manager for nine months and several short-term managers. We have been informed that a new manager had been recruited and would be starting employment soon and registering with the Care Quality Commission (CQC).

Risk of harm to people had not always been mitigated as good practice guidelines for the management of continence, wound care and pressure care management. There was a lack of guidance and analysis in managing some people's behaviours that challenge and there was no evidence of what strategies worked and what staff could try next time, This meant that people's safety and welfare had not been maintained at all times.

There were sufficient staff to meet people's individual needs, however the deployment of staff had not always ensured that peoples' needs were met in a timely manner. Staff had passed robust recruitment procedures which ensured they were suitable for their role.

Whilst there were areas of care planning and assessing risk to people that needed to be improved, there were also systems to monitor people's safety and promote their health and wellbeing, these included health and social risk assessments and care plans. The provider ensured that when things went wrong, lessons were learned.

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

Staff received appropriate training and support to enable them to perform their roles effectively. Visitors told us, "The care seems really good, they seem well trained and competent," and "I know the staff get training, I have no worries or complaints."

People's nutritional needs were monitored and reviewed. People had a choice of meals provided and staff

knew people's likes and dislikes. People gave positive feedback about the food. Comments included, "We get choices, the food is good most of the time, it can't be easy to please all of us."

People and relatives told us staff were 'kind' and 'caring'. They could express their views about the service and provide feedback. One person said, "I am very happy living here, the staff are nice and friendly and very kind."

People were encouraged to live a fulfilled life with activities of their choosing and were supported to keep in contact with their families. One person told us, "I have a mobile phone and staff make sure it's charged and ready in the morning, then I can ring my family if I want to."

People's care was person-centred. The care was designed to ensure people's independence was encouraged and maintained. The dementia unit was designed to enable people who lived with dementia to walk safely and the provision of items on walls and in corridors provided stimulation and interest. Staff supported people with their mobility and encouraged them to remain active. One visitor told us that since coming to Lauriston their relative was more mobile and confident, "They encourage people to walk, even if it's just a short one, it gives my relative an incentive to keep moving."

People and families were involved in their care planning as much as possible. End of life care was planned for and staff confirmed they received training.

Referrals were made appropriately to outside agencies when required. For example, GPs, community nurses and speech and language therapists (SALT).

Notifications had been completed to inform CQC and other outside organisations when events occurred.

The service met the characteristics for a rating of Requires Improvement.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection: Good. (Report published on 28 October 2016.)

Why we inspected:

This inspection was brought forward due to information of risk and concern. CQC received concerns in respect of staffing level (high use of agency staff) lack of leadership and poor care delivery. The concerns raised were looked at during this inspection and have been reflected in the report.

Enforcement:

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Follow up:

We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe

Details are in our Safe findings below.

Requires Improvement ●

Is the service effective?

The service was effective

Details are in our Effective findings below.

Good ●

Is the service caring?

The service was caring

Details are in our Caring findings below.

Good ●

Is the service responsive?

The service was responsive

Details are in our Responsive findings below.

Good ●

Is the service well-led?

The service was not always well-led

Details are in our Well-Led findings below.

Requires Improvement ●

Lauriston

Detailed findings

Background to this inspection

The inspection:

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

Inspection team:

The inspection team consisted of an inspector and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses care services. In this instance services for older people and those who live with dementia.

The service is required to have a registered manager:

The service did not have a manager who was registered with the Care Quality Commission. The organisation were in the process of recruiting a manager who will immediately be submitting an application to register with the Care Quality Commission.

The service type:

The Lauriston 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.

Notice of inspection:

We did not give the provider any notice of this inspection.

Why we inspected:

The inspection was prompted in part by a high level of notifications, safeguarding and concerns raised anonymously about care delivery and staffing levels.

What we did:

Before the inspection we reviewed the information, we held about the service and the service provider, including the previous inspection report. The registered provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications and any safeguarding alerts we had received for this service. Notifications are information about important events the service is required to send us by law.

During the inspection we spoke with:

16 people and observed care and support given to people in the dining room and lounges

Nine people's relatives/visitors.

11 members of staff

Three external healthcare professionals.

We also reviewed the following documents:

Eight people's care records

Records of accidents, incidents and complaints

Four staff recruitment files and training records

Audits, quality assurance reports and maintenance records

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Assessing risk, safety monitoring and management:

- Whilst there were processes to protect people from avoidable harm, there were areas that needed to be improved to ensure peoples' health and well-being. For example, there were people who had been assessed as being at high risk of developing pressure damage and preventative measures such as pressure relieving cushions and regular re-positioning had not been followed. For example, one person who had been assessed as high risk of pressure damage sat in a wheelchair in the lounge for up to six hours without being offered any change of position or a comfort break. Staff had not ensured a pressure relieving cushion was in place and the person did not have access to a call bell to request assistance.
- Peoples continence needs had not always been met and had placed them at risk of moisture lesions and sore skin. For example, one person showed us that their bed and nightwear and incontinence pad was soaked with urine at 930 am. They were not able to access their call bell and were not independently mobile. Despite requesting immediate support for this person, their personal needs were not met until 11 30 am.
- There was a wound care folder. This folder included the wound risk assessment, photographs, tissue viability nurse advice and a log of the wound progress and dressings used by the nurses. However not all wounds had been documented and recorded. This was rectified during the inspection.
- For some people who lived with behaviours that may challenge, there was little information in the care plan to guide staff on how to manage these behaviours that challenge. Staff talked about certain triggers for people, but these were not always recorded in the persons care plan. ABC behavioural charts were used but lacked information about how staff dealt with behaviours that challenged and if the de-escalation technique was successful.
- Call bells to summon assistance had not always been provided in communal areas. This meant when staff were busy elsewhere, people could not ask for help or alert staff they needed assistance. For example, one person had been left alone in a dining room after lunch in their wheelchair for over an hour. They expressed their concern to us that they may miss the afternoon activity.
- People who were approaching their end of life had been prescribed just in case medicines. However, there were no pain risk assessments or guidance for staff to follow to ensure people received these important medicines in a timely way.

The above evidence shows that care and treatment had not always been provided in a safe way. Risk of harm to people had not always been mitigated as good practice guidelines for the management of wounds, pressure damage and continence care. This meant that people's safety and welfare had not been adequately maintained at all times and is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We also saw good examples of risk management that had been completed, for example, risk of falls and risk of choking. Staff reviewed risk assessments monthly and put actions in place to reduce these risks. For example, ensuring a person who was at risk of choking was provided with a pureed diet and modified texture fluids.
- People who were identified at risk from falls had had an assessment that highlighted the risk and described the actions staff should take to reduce that risk. Sensor mats were used to alert staff that a person was up and was at risk of falls.
- The environment and equipment continued to be well maintained. People told us that any issues were dealt with straight away. One person said, "It's lovely and clean, the cleaners are excellent." Another person said, "Very clean, the laundry is good too."
- There were detailed fire risk assessments, which covered all areas in the home. People had Personal Emergency Evacuation Plans (PEEPs) to ensure they were supported in the event of a fire. These were specific to people and their needs.
- Premises risk assessments and health and safety assessments continued to be reviewed on an annual basis, which included gas, electrical safety, legionella and fire equipment. The risk assessments also included contingency plans in the event of a major incident such as fire, power loss or flood.
- People told us "I am safe because of where I am placed; I can talk to my key worker or the lady in the office, " I like the staff, I feel safe," and "I love the staff here, I feel safe, and everything is good," and "Very nice here, I feel safe."

Staffing and recruitment:

- Staff deployment had not always ensured people's needs were met in a timely manner and in a way that met their preferences.
- Staff deployment on the residential unit needed to be reviewed as people were left waiting for essential care whilst the senior care staff member gave medicines out on the residential and dementia unit in the morning. We also saw people who had to wait to leave the dining area at lunch time and they were left unattended without access to call bells. This was discussed with the area manager who investigated the shortfalls during the inspection and took appropriate action to ensure that the incidents seen would not happen again. One action taken was to ensure pendant call bells were given to people. On the second day of inspection the deployment had ensured that people's needs were met in a timely manner.
- Staff told us that there were enough staff to do their job safely and well. Staff on the dementia unit told us, "We have enough staff, but we share staff with the residential unit and that can delay what we do," and "It is short staffed sometimes, we do get agency staff, which are okay, but it does take longer as they don't know everything." Relatives said, "I'm sure we all say the same thing, more staff but they seem to have enough staff most of the time," and "Very happy with my Dad's care here, they do their absolute best here and that is all you can ask for, he needs feeding and observation, there seems to be enough staff." A person told us, "They have volunteers here and that makes a difference, because they sit with us and chat."
- We looked at four staff personnel files and there was evidence of continuing robust recruitment procedures. All potential staff were required to complete an application form and attend an interview, so their knowledge, skills and values could be assessed.
- The provider continued to undertake checks on new staff before they started work. This included checking their identity, their eligibility to work in the UK, obtaining at least two references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.
- The service does use agency staff. The area manager said, "We try to use the same staff from the agency, so the residents get to know them, and the staff get to know how Lauriston works." All agency staff complete an induction before starting work at Lauriston. This included a tour, introduction to staff and the people and emergency procedures.

Using medicines safely:

- People's medicines continued to be managed and were administered safely and our observations confirmed this.
- Both registered nurses and senior carers gave medicines to people. Medicine givers were trained to handle medicines in a safe way and completed competency assessments. This ensured their knowledge was up to date. Staff told us that they received training from the dispensing chemist and support from the registered nurses.
- Medicines continued to be stored, administered and disposed of safely. People's medication records confirmed they received their medicines as required. We saw medicines remained stored securely when being given out, medicine gives ensured the trolley was locked.
- Medicines prescribed on an 'as and when required' basis (PRN) had protocols which informed staff of when the medicines were required.
- Homely remedy guidance had been reviewed and agreed with the GP. A homely remedy is a product that can be given without a prescription, for the immediate relief of a minor, self-limiting ailment..

Preventing and controlling infection:

- Lauriston was well- maintained, clean and free from odour. People told us the home was clean and comfortable. They told us, "Overall, it is clean and tidy here, if anyone has an accident it is cleaned up quickly." A visitor told us, "Always clean and tidy."
- Staff confirmed they had received training in infection control measures. Staff could tell us of how they managed infection control and were knowledgeable about the in-house policies and procedures that govern the service.
- Staff continued to have access to personal protective equipment (PPE) such as disposable gloves and aprons. Our observations showed staff had a good understanding of infection control procedures and we saw good practices from all staff throughout our inspection.
- Staff confirmed they had received training in infection control measures. Staff could tell us of how they managed infection control and were knowledgeable about the in-house policies and procedures that govern the service.

Systems and processes to safeguard people from the risk of abuse:

- People were protected from the risks of abuse and harm. Staff were aware of the signs of abuse and how to report safeguarding concerns. They were confident the management team would address any concerns and make the required referrals to the local authority. A staff member said, "We get training, which is interesting and helpful." Another staff member said, "We all get training regularly and we are supported to ask questions if we see something that concerns us."
- There was a safeguarding and whistleblowing policy which set out the types of abuse, how to raise concerns and when to refer to the local authority.
- The organisation had followed safeguarding procedures, made referrals to their local authority, as well as notifying the Care Quality Commission. There was a safeguarding folder that contained the referral and investigation document. It also contained the outcome of the investigation with action plans where required. Feedback from the local authority included "They do work with us, they inform us of events and accidents in a timely way."
- Staff received training in equalities and diversity awareness to ensure they understood the importance of protecting people from all types of discrimination. The Provider had an equalities statement prominently displayed in the entrance of the home. The statement recognised the organisations commitment as an employer and provider of services to promote the human rights and inclusion of people and staff who may have experienced discrimination due to their ethnicity, religion, sexual orientation, gender identity or age.

Learning lessons when things go wrong:

- Accidents and incidents were documented and recorded. We saw incidents/accidents were responded to by updating people's risk assessments. Any serious incidents were escalated to other organisations such as the Local Authority and CQC.
- The provider had a system in place to facilitate the analysis of incidents and accidents and the registered manager used this to identify themes and learning. For example, if incidents were occurring at a specific time of day or in one place. The provider then took appropriate action such as looking at staff deployment or one to one support. This was seen during the inspection.
- Specific details and follow up actions by staff to prevent a re-occurrence were clearly documented in the folder and cross referenced back into the care plan of the person to alert staff.

Is the service effective?

Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

Supporting people to eat and drink enough to maintain a balanced diet:

- People told us that the food at Lauriston was good. Comments included, "I think the food is good, we get a choice from the menu, you can ask for something to be done for you, the roasts are good, I do get enough to eat and drink, I can ring if I want a snack." "I can eat in my room or the dining room, I am fine with mealtimes." We were also told, "Food is very nice, I get a choice," and "Food is mediocre, I get a choice, far too much to eat, so much waste, you can have snacks whenever you want."
- Visitors told us, "Very good variety, always nicely presented." People were shown the meal choices as the meal service began, which meant that they could visually make their choice.
- The chef knew the people he prepared food for. He visited people to discuss their dietary requirements and knew who required special diets and fortified food. The chef had been in post for three years and knew the residents very well.
- There were appropriate risk assessments and care plans for nutrition and hydration.
- Choking risk assessments were completed where a risk was identified. Referrals to a speech and language therapist (SALT) had been made when necessary. Emergency equipment such as a suction machine were available, and staff had been trained in emergency first aid and how to act if someone choked.
- People had correctly modified texture diets and fluids where there were risks of choking. All meals were attractively presented to encourage people to eat. Staff assisted those that required assistance with eating in an unhurried way.
- Staff monitored peoples' weights and recorded these on the nutritional assessment. The registered managers had a 'tracker' which noted people's weights and malnutrition scores. These could be traced over time to check whether there were any risks and flag staff to request a dietitian's input. Staff could tell us who was at risk from malnutrition and dehydration. They could also tell us what actions they needed to take such as encouraging drinks and fortified food.

Ensuring consent to care and treatment in line with law and guidance:

- The MCA provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
- People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
- We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- The provider had a good understanding of the Act and were working within the principles of the MCA.

People were not unduly restricted and consent to care and treatment was routinely sought by staff.

- Staff understood when a DoLS application should be made and the process of submitting one.
- We were told that not everyone currently living at the home had the capacity to make their own decisions about their lives and were subject to a DoLS.
- There was a file kept by the registered manager of all the DoLS submitted and their status. The documentation supported that each DoLS application was decision specific for that person. For example, regarding restricted practices such as locked doors, sensor mats and bed rails.

Supporting people to live healthier lives, access healthcare services and support: Staff working with other agencies to provide consistent, effective, timely care:

- A range of multi-disciplinary professionals and services continued to be involved in assessing, planning, implementing and evaluating people's care, treatment and needs.
- Links with other organisations to access services, such as tissue viability services and speech and language therapists (SaLT) continued to ensure effective care. This was clear from the care planning documentation and the professional visiting logs. A visiting healthcare professional told us, "The staff seem to know their residents very well, they ask for advice and call us in when it is needed." Relatives told us "The care my mother is getting is excellent," and "The staff keep us updated if either of them are unwell or have had an accident."
- People were assisted with access to appointments. People told us, "When I have had an appointment, someone goes with me," and "Staff organise appointments for me."
- Information was shared with hospitals when people visited. Each person had an information sheet that would accompany the person to hospital. This contained essential information about the person, such as how they communicated, mobility and medicines.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:

- We saw staff continued to apply best practice principles, which led to effective outcomes for people and supported a good quality of life.
- Where required, healthcare professionals were involved in assessing people's needs and provided staff with guidance in line with best practices, which contributed to good outcomes for people.
- People's health needs continued to be assessed using recognised risk assessment tools, such as waterlow (this is used to assess risk of pressure sores). Care plan reviews took place at least monthly, or as and when required.
- People's past life histories and background information were also recorded in the care documentation.

Staff support: induction, training, skills and experience:

- People told us, "I feel confident that the staff have the skills to look after me well." A second person told us, "Staff know what they are doing." A third commented, "Staff look after us very well, they notice when I'm not myself and get the doctor in to see me."
- The staff spoke positively about the training sessions they had received. One staff member told us, "The training is pretty good, we can also suggest training."
- The provider provided staff with regular training to ensure they had the right knowledge and skills to carry out their roles. Staff told us that they completed essential training such as infection control, moving and handling and safeguarding. They also confirmed that they had specific training such as understanding dementia, catheter care, epilepsy and equality and diversity. The training records confirmed that training had been completed.
- There was a combination of e-learning and face-to-face training.
- Staff training records reflected the information provided by the registered managers and confirmed that staff had been supported to gain the Health and Social Care diploma.
- Records showed staff supervision had taken place regularly and the staff we spoke with felt supported.

- Staff received an induction and shadowed experienced staff before they worked with people on their own. The organisational induction was in line with the Care Certificate. The Care Certificate is an identified minimum set of standards that health and social care workers adhere to in their daily working life.
- Agency staff had an induction that introduced them to the home, emergency procedures and residents.

Adapting service, design, decoration to meet people's needs:

- Lauriston was a purpose-built building. Designed to provide a spacious and comfortable environment over two floors. The home is divided in to three units, dementia, residential and nursing. The building was well decorated. The walls in the dementia unit displayed many tactile pictures / murals and things to encourage memory and stimulation. Memory boxes were on the walls outside bedrooms to enable people to recognise their room and gave insight to staff about the person it pertained to.
- People could choose to sit in the spacious lounges, quiet lounges on each floor, dining areas or in their own rooms.
- People's rooms remained personalised and individually decorated to their preferences. We saw that people's rooms reflected their personal interests. For example, one person had lots of photographs, pictures and extra shelving to make it feel like home.
- The garden areas were well designed and safe and suitable for people who used walking aids or wheelchairs.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well-treated and supported; equality and diversity:

- People continued to receive kind and compassionate support from staff.
- People were observed to be treated with kindness and were positive about the staff's caring attitude.
- Throughout our inspection, people and families provided consistently positive feedback about staff and the service. Visitors told us, "Very kind and caring, I have never had any worries," and "Oh what kind people here." People told us, "Even when busy they are kind and helpful," and "Very nice team of staff, there have been new faces but that's normal I suppose."
- Relatives confirmed how care workers would work to people's personal instructions and cared for them in the way they chose.
- People's equality and diversity was recognised and respected. People were supported to wear the clothes they wanted. One person specifically liked to wear make-up and staff ensured they respected this wish.
- People's religious preferences were respected. The Chaplain was in the home four days a week and provided providing a listening presence, companionship and one-to-one pastoral support for all residents, their friends and relatives, and staff members - irrespective of their beliefs - and organise worship for those who wish to participate.
- People were encouraged to maintain their independence and live a life they wanted. People who lived with the beginnings of dementia were treated in the same way as people who were not living with dementia. They were offered the same opportunities to join activities and chose where they spent their time. One staff member said, "Everybody is treated the same way." One person told us, "I can choose what I do, staff help me." Another person told us they liked to spend their time in their own room and staff respected this.

Supporting people to express their views and be involved in making decisions about their care:

- People and families continued to be involved in reviews. Some people could tell us that they were involved in planning their care. One person told us, "They have involved me in care decisions and I can speak to staff about anything." Another person said, "They always talk to me"
- Records confirmed regular meetings were held with people and their relatives or friends had the opportunity to attend. Multi-disciplinary meetings were held, and people were involved in these meetings to discuss their needs and make decisions about the care.
 - People told us they had been involved in planning their move to the service. One person told us, "I came here in November last year. It was my decision, but the staff here made it an easier decision because they listened to what I needed and didn't push their ideas on me."

Respecting and promoting people's privacy, dignity and independence:

- Staff continued to treat people with dignity and respect and provided support in an individualised way.
- People's right to privacy and confidentiality was respected. One person told us, "Definitely the staff are

respectful, they always knock on my door, and I can always discuss my care with the staff." Another person said, "They always ensure my dignity." A visiting professional commented, "I have only seen good practice, I see people in their room for privacy."

- Staff continued to promote peoples' independence. One person told us, "Staff encourage me, for myself and help if I need it. I can choose when I get up and go to bed, what I eat and what I get up to, I like to be in the lounge with my friends." A relative told us, "I fought hard to get him back in here from hospital, they got him walking again here, staff are very kind and caring, even the young staff."

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

- People were supported to exercise choice and control in their day to day lives and were empowered to make their own choices about what they do with their time.
- People's needs assessments included comprehensive information about their background, preferences and interests. This information helped staff to initiate topics of conversation that were of interest to people. We were told conversations with people about their history and background reassured people, particularly if they had difficulty with their memory. A staff member said they had read people's care plans and it had helped her to understand them and care for them.
- Some people could tell us they were involved in planning their care. One person said, "I have a Care plan and it is reviewed, no one originally spoke about it, but I was poorly," and "I have a key worker, I get on well with her, and she is lovely" A care staff member said, "We involve people as much as we can, some people don't want to be involved and some people can't tell us, so we look to involve family and friends."
- Staff provided examples of how they supported people to choose their preferred care. Such as, choosing to have a wash, shower or bath, the time people wished to go to bed and get up, the clothes they liked to wear and the food and drink they preferred.
- Where people had specific health care needs, these were identified and showed how people should be supported. Staff could explain where and how this support should be provided. For example: people who lived with diabetes had a person specific care plan that identified clearly the persons' diabetic needs, the complications they might experience and how staff could recognise the symptoms for that person if their blood sugar dropped or was too high. There was clear information of how much insulin was required according to their blood sugar range. This ensured staff could manage their care responsively and effectively.
- Reviews took place to ensure people's needs were accurate and were being met to their satisfaction and involve their family or legal representative. Where an advocate was needed, staff supported people to access this service.
- Staff spoke knowledgeably about people's needs as well as their interests, which was reflected in people's care assessments and plans. One staff member said, "I read about their lives and why they are here, it makes me understand them better."
- People and relatives told us they were impressed with the range of activities provided and spoke highly of the activity co-ordinators and the work they did. People commented, "I love the indoor ball games, it's my favourite." Other comments included, "I read, watch TV and listen to music, I have a lot of my own things in my room," "There was a Fayre downstairs which I enjoyed and bought lots of books, my family are always made welcome at any time." Relatives told us, "The activities are excellent; she goes to the lounge, anything to do with music or animals," and "My Mum likes the music and bingo, they both enjoy the garden."
- There was a wide range of activities organised and these included, flower arranging, visits from exotic pets, cooking sessions and arts and crafts. The organisation has a team of music therapists that provide one to

one sessions for individual people who staff had referred as they had thought it would prove beneficial. The music therapy is funded by charitable donations. We met one person who we had noted walking all day and not interacting with staff. This person was brought through to the lounge which had a piano. The person immediately started playing the piano and the difference it made to the person was lovely to see. They also sang with the music therapist and their enjoyment was clear to see.

- Care plans demonstrated consideration was given to people's individual religious and cultural needs. Clergy from various faith groups attended the home on a regular basis and we noted in one person's care records it stated that staff should remind this person when a visit from the clergy was due.
- All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements.
- People's communication and sensory needs were assessed, recorded and shared with relevant others. The documents created to go with people go to hospital, had peoples' communication needs clearly documented.
- There were specific details in people's care plans about their abilities, needs and preferred methods of communication.
- Notice boards were covered with information about up and coming events or something interesting or attractive to look at. There was pictorial signage around the home to help orientate people.

Improving care quality in response to complaints or concerns:

- There were processes, forms and policies for recording and investigating complaints.
- There was a satisfactory complaints policy. People also had access to the service users guide which detailed how they could make a complaint.
- The provider kept a complaints log which showed that complaints were taken seriously, responded to appropriately. There was also evidence that complaints were analysed and lessons taken forward to improve care. One person said, "I have made a complaint about an agency staff; I wrote to the manager, the matter was dealt with appropriately, I was happy with what they did."

End of life care and support:

- Staff attended palliative/end of life care training and there was a provider policy and procedure containing relevant information about end of life care. Staff demonstrated that they felt prepared and understood how to support people at the end of their life.
- Care plans identified people's preferences at the end of their life and the service co-ordinated palliative care in the care home where this was the person's wish.
- Care plans contained information and guidance in respect of peoples' religious wishes.
- The Lauriston had a dedicated Chaplain, who offered pastoral support to every person whatever their beliefs. The chaplain provided support, a listening presence and one to one support at this time of their life.
- Staff demonstrated compassion towards people at the end of their life. They told of how they supported them health and comfort wise. This included regular mouth care and position moving. We were also told that families were supported and that they could stay and be with their loved ones at this time.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Aspects of leadership and management did not consistently assure person-centred, high quality care.

Managers and staff were clear about their roles, and understanding quality performance, risks and regulatory requirements:

- There was no clear leadership at the Lauriston at this time. There had been several short-term managers since the resignation of the registered manager in September 2018. This had impacted on staff morale. One staff member said, "It's been really difficult because we haven't had a manager since mid-last year, we need a full-time manager that we can talk to." People told us, "The manager has left, there is a new one starting soon I believe," and "There have been quite a change of managers, but I have been told there is a new one starting soon." Visitors told us, "We were aware of the manager, he has left, not met a new one yet."
- Despite the lack of leadership structure, people were positive about the service. Comments included, "I can't really fault it as a caring, safe and clean place with nice people, I am still adapting to being here," "On the whole the quality of care I get is very good, pretty good and homely atmosphere." "Very good care here, really homely atmosphere, like a proper home here." Visitors told us, "The atmosphere is happy, friendly and the staff are very good," "We can visit whenever we like, we are always made welcome by the staff," and "We are happy with the care our mothers are receiving."
- The provider and area manager had continued to implement quality assurance processes. These included audits of care plans, staff files, complaints, safeguarding concerns, incidents and accidents, and quality satisfaction surveys.
- However, as discussed with the management team during the inspection, the systems had not identified some of the shortfalls we found. For example, we found some information in care plans had not been followed in respect of pressure care management. One person had been identified as being at risk from pressure damage and the care plan stated a pressure relieving cushion should be used. The person was not sitting on a pressure relieving cushion and therefore risk was not always mitigated.
- Staff deployment had not ensured people received the care they needed in a timely manner.
- Daily notes and behavioural charts were not always detailed and lacked meaningful information. For example, daily notes for one person described the person's actions and distress but lacked detail on how staff responded to allow an analysis of how best to support them.

The above examples, demonstrate that the provider's quality assurance framework was not consistently robust and the provider had failed to maintain accurate, complete and contemporaneous records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:

- People and their relatives felt that communication between them and the home was open and transparent. A relative told us, "The staff keep us informed, they let us know of any accidents and incidents,"

and "They ring up with any developments and changes, very good I would say." There was one negative comment about communication which is currently being investigated by the area manager.

- Staff told us that the organisational management support was good and that they were listened to when they raised any issues or concerns. Feedback included, "We can talk to the senior management but obviously they are not always here."
- Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events including significant incidents and safeguarding concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:

- People and relatives confirmed they attended meetings and were asked their views on the running of the service
- Resident meetings are held monthly and minutes are displayed on the notice board so people can see that their comments have been taken forward. People told us, "I go to the resident's meetings, sometimes they are helpful, and I can shout if things are not right," and "I don't always go to the meetings, but it was interesting." Visitors told us, ""We have been to a relatives meeting which was beneficial, very good, we came up with ideas which is good."
- Regular care staff, registered nurse meetings and heads of department meetings encouraged effective communication and gave staff an opportunity to raise concerns, make suggestions and share good practice. Staff said they used the meetings to discuss topics such as training, staffing and use of agency staff. One staff member said, "If I felt there was something I would speak up – I would be listened to." This showed staff were involved in shaping and understanding the service.
- People were supported to complete surveys about the service to capture their views and opinions. We saw evidence that indicated people's feedback led to changes including new menus and improved laundry systems. In this way the service could find out people's preferences and involve them with how the service worked.

Continuous learning and improving care:

- Throughout our inspection we saw evidence that the organisation was committed to drive continuous improvement.
- The provider and registered managers were open and transparent when discussing the areas to further develop and immediately started to put actions into place. For example, updating care plans immediately when identified.
- A member of staff told us the organisation encouraged learning. The team were able to access career development opportunities and qualifications, and ideas were shared from other services within the organisation. The staff member believed this had contributed to their learning and skills had improved and good practice ideas shared.
- Staff told us there was not a "blaming culture" at the service. The area manager told us they facilitated coaching sessions and reflective opportunities, and staff confirmed this. One staff member said, "If something has happened and there is a complaint or safeguarding, it's investigated, and we get the opportunity to discuss how it could have been prevented. It helps us learn and that is good."
- Staff knew how to report accidents and incidents and told us they received feedback about changes and learning as a result of incidents at group supervision and on an individual basis. The provider used their analysis of accidents and incidents as a learning tool.

Working in partnership with others:

- Lauriston continued to work in partnership with the local community, other services and organisations, such as the local authority.

- Health and social care professionals confirmed the service communicated and worked effectively with other agencies to benefit people using the service.
- Staff continued to hold multi-disciplinary team meetings to discuss people's needs and wishes. A visiting professional told us, "I've been involved in reviews with the person, GP and families and have always been made welcome."
- The service had a good working relationship with the local authority and contract monitoring officers and took the initiative to seek feedback from the safeguarding team. The organisation welcomed feedback as a learning tool to prevent a re-occurrence. Staff confirmed that they received feedback following a safeguarding investigation of any areas that they could improve. One staff member said, "It's always worrying if we have got it wrong for someone, but this feedback helps us all to improve."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured the safety of service users by assessing the risks to their health and safety and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 12(1)(2)(a)(b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured that there were effective systems to assess and quality assure the service. Regulation (17) (1) (2) (a). The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. Regulation 17 (2) (c).