Methodist Homes

Lauriston

Inspection report

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20 October 2016

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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

Lauriston provides nursing and personal care for up to 60 people, some of whom lived with dementia. The home had been divided into three units over two floors. The first floor unit provided nursing care and support for 25 people with a range of illnesses, such as Parkinson's disease, Multiple Sclerosis and strokes, some of whom were also receiving end of life care. The ground floor residential units were divided by a locked door and provided personal care and support for up to 15 people living with dementia and six people who were physically frail. Lauriston also provides short stay care known as respite care. At present there are five beds that are blocked by the local authority for residential short stay.

A registered manager is in post. 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 and associated Regulations about how the service is run.

We carried out an unannounced comprehensive inspection at Lauriston on the18 and 20 February 2015. Breaches of Regulation were found and Lauriston was rated as inadequate. A further inspection was undertaken on 30 June and 01 July 2015 to follow up on whether the required actions had been taken to address the breaches identified. We found that the breaches of regulation had been met but needed time to be embedded in to everyday care delivery and Lauriston therefore was rated as requires improvement.

This unannounced comprehensive inspection was carried out on the 14, 18 and 20 October 2016 to see if the improvements had been sustained. We found that the improvements had been sustained.
People spoke positively of the home and commented they felt safe. Our own observations and the records we looked at reflected the positive comments people made.

Care plans reflected people's assessed level of care needs and care delivery was person specific, holistic and based on people's preferences. Risk assessments included falls, skin damage, behaviours that distress, nutritional risks including swallowing problems and risk of choking and moving and handling. For example, cushions were in place for those that were susceptible to skin damage and pressure ulcers. The care plans also highlighted health risks such as diabetes and epilepsy. Visits from healthcare professionals were recorded in the care plans, with information about any changes and guidance for staff to ensure people's needs were met. Staff had received training in end of life care supported by the organisations pastoral team. There were systems in place for the management of medicines and people received their medicines in a safe way.

Nurses were involved in writing the care plans and all staff were expected to record the care and support provided and any changes in people's needs. The manager said care staff were being supported to do this and additional training was on-going. Food and fluid charts were completed and showed people were supported to have a nutritious diet.

Staff had a good understanding of people's needs and treated them with respect and protected their dignity when supporting them. People we spoke with were very complimentary about the caring nature of the staff. People told us care staff were kind and compassionate. Staff interactions demonstrated staff had built rapport with people and they responded to staff with smiles. People previously isolated in their room were seen in communal
lounges for activities, meetings and meal times and were seen to enjoy the atmosphere and stimulation.

A range of activities were available for people to participate in if they wished and people enjoyed spending time with staff. Activities were provided throughout the whole day, seven days a week and was in line with people's preferences and interests.

The provider had progressed quality assurance systems to review the support and care provided. A number of audits had been developed including those for accidents and incidents, care plans, medicines and health and safety. Maintenance records for equipment and the environment were up to date, such as fire safety equipment and hoists. Policies and procedures had been reviewed and updated and were available for staff to refer to as required. Staff said they were encouraged to suggest improvements to the service and relatives told us they could visit at any time and, they were always made to feel welcome and involved in the care provided.

Staff and relatives felt there were enough staff working in the home and relatives said staff were available to support people when they needed assistance. The provider was actively seeking new staff, nurses and care staff, to ensure there was a sufficient number with the right skills when people moved into the home. The provider had made training and updates mandatory for all staff, including safeguarding people, moving and handling, management of challenging behaviour, pressure area care, falls prevention and dementia care. Staff said the training was very good and helped them to understand people's needs.

All staff had attended safeguarding training. They demonstrated a clear understanding of abuse; they said they would talk to the management or external bodies immediately if they had any concerns, and they had a clear understanding of making referrals to the local authority and CQC. Pre-employment checks for staff were completed, which meant only suitable staff were working in the home. People said they felt comfortable and at ease with staff and relatives felt people were safe.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider, registered manager and staff had an understanding of their responsibilities and processes of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff said the management was fair and approachable, care meetings were held every morning to discuss people's changing needs and how staff would meet these. Staff meetings were held monthly and staff were able to contribute to the meetings and make suggestions. Relatives said the management was very good; the registered manager was always available and, they would be happy to talk to them if they had any concerns.

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

Lauriston was safe. There were systems in place to make sure risks were assessed and measures put in place where possible to reduce or eliminate risks. Medicines were stored and administered safely.

Comprehensive staff recruitment procedures were followed. There were enough staff to meet people's individual needs. Staffing arrangements were flexible to provide additional cover when needed, for example during staff sickness or when people's needs increased.

Staff had received training on safeguarding adults and were confident they could recognise abuse and knew how to report it. Visitors were confident that their loved ones were safe and supported by the staff.

Is the service effective?

Good

Lauriston was effective. Staff received training which was appropriate to their job role. This was continually updated so staff had the knowledge to effectively meet people's needs. They had regular supervisions with their manager, and formal personal development plans, such as annual appraisals.

Staff had a good understanding of people's care and mental health needs. Staff had received essential training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and demonstrated a sound understanding of the legal requirements.

People were able to make decisions about what they wanted to eat and drink and were supported to stay healthy. They had access to health care professionals for regular check-ups as needed.

Is the service caring?

Good

Lauriston was caring. Staff communicated clearly with people in a caring and supportive manner. Staff knew people well and had good relationships with them. People were treated with respect

and dignity.

Each person's care plan was individualised. They included information about what was important to the individual and their preferences for staff support.

Staff interacted positively with people. Staff had built a good rapport with people and they responded well to this.

Is the service responsive?

Good

Lauriston was responsive. People had access to the complaints procedure. They were able to tell us who they would talk to if they had any worries or concerns.

People were involved in making decisions with support from their relatives or best interest meetings were organised for people who were not able to make informed choices.

People received care which was personalised to reflect their needs, wishes and aspirations. Care records showed that a detailed assessment had taken place and that people were involved in the initial drawing up of their care plan.

The opportunity for social activity and outings was available should people wish to participate.

Is the service well-led?

Good

Lauriston was well-led. Management was visible within the home and staff felt supported within their roles. Systems were in place to obtain the views of people, visitors and healthcare professionals. The manager was committed to making on-going improvements in care delivery within the home, striving for excellence.

There was an open culture, and people and quality care were at the heart of the service.

Staff were well motivated, worked as a team and wanted to make sure they supported people in a caring and person centred way.

There were systems in place to monitor the quality of the service and any areas for improvement identified were dealt with quickly.

Lauriston

Detailed findings

Background to this inspection

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

We visited the home on the 14, 18 and 20 October 2016. This was an unannounced inspection. The inspection team consisted of one inspector.

During the inspection, we spoke with 12 people who lived at the home, five visiting relatives, eight care staff, three registered nurses, two cleaners, the area manager, the registered manager and the activity co-ordinators. We also contacted external health professionals, such as the tissue viability nurse, GP and speech and language therapists to gain their views of the service.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home. Before the inspection, the provider 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 areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also used communication aids that people themselves used, to communicate with them.

During the inspection we reviewed the records of the home. These included staff training records and policies and procedures. We looked at four care plans from the nursing floor, one respite care plan and three care plans from the dementia unit. We also looked at risk assessments along with other relevant

documentation to support our findings. We also 'pathway tracked' people living at Lauriston This is when we looked at people's care documentation in depth and obtained their views on how they found living at Lauriston. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

People told us they felt safe living at Lauriston. One person told us, I feel very secure living here." Another person said, "I have no concerns, I'm happy and safe here." Relatives said, "The staff are very good, they make sure people are safe, even when they want to walk around." Another relative told us their family member was safe and settled and they did not worry about their safety. Staff expressed a strong commitment to providing care in a safe and secure environment.

Individual risk assessments had been implemented, reviewed and updated to provide sufficient guidance and support for staff to provide safe care. Risk assessments for health related needs were in place, such as skin integrity, nutrition, falls and dependency levels. Care plans demonstrated how people's health and well-being was being protected and promoted. We saw detailed plans that told staff how to meet people's individual needs. For example, continence care was identified and a plan of action for staff to follow such as regular visits to the bathrooms and application of topical creams was in place. Another care plan told staff how to meet behaviours that challenge in a way that ensured people and staff safety and well-being. We saw care plans that contained information about people's skin integrity alongside the risk assessment to identify people's individual risk to pressure ulcers.

There were people who presented with behaviours that could be challenging and staff were seen to manage situations in a way that ensured people remained safe. Staff remained observant but respected peoples' personal space and managed to de-escalate situations quietly and professionally. We saw that staff used observation charts that they completed following an incident and these records were used to review triggers and the management of behaviours.

We observed safe transfers (people being supported to move from a wheelchair to armchair with the support of appropriate equipment). The transfers we observed showed that staff were mindful of the person's safety and well-being.. Staff offered support and reassurance and people told us they felt safe whilst being moved by staff. One person said, "I trust them to keep me safe." People's care documentation and risk assessments reflected the lifting equipment and size of sling to be used. People had their own personal sling which reduced the risk of cross infection.

A system was in place to record accidents/incidents with actions taken to prevent them as far as possible. Accidents were recorded with information about what had happened, such as an unwitnessed fall in a person's bedroom or in the communal areas. The information recorded included action taken to prevent a further accident, such as increased checks and a sensor mat. Audits were carried out for the accident/incident forms to ensure sufficient information was recorded. Accidents were reported to the local authority in line with safeguarding policies.

Medicine records showed that each person had an individualised medicine administration sheet (MAR), which included a photograph of the person with a list of their known allergies. MAR charts indicated that medicines were administered appropriately and on time (MAR charts are a document to record when people received their medicines). Records confirmed medicines were received, disposed of, and administered

correctly. People confirmed they received their medicines on time. One person told us, "I get all my medicines when I need them." There was clear advice on how to support people to take their medicines including 'as required' (PRN) medicines, such as paracetamol. People's medicines were securely stored in a clinical room and they were administered by registered nurses and senior care staff who had received appropriate training. We observed two separate medicine administration times and saw that medicines were administrated safely and that staff signed the medicine administration records after administration. The clinical room was well organised and all medicines were stored correctly and at the correct temperature. There was a clear audit trail that defined what action was taken following errors, such as medicine retraining and competency tests.

People were supported to live an independent life style as far as possible despite living with a wide range of illnesses such as dementia, Parkinson's and diabetes. The manager and staff understood the importance of risk enablement, this meant measuring and balancing risk. Staff member said, "We want to ensure people live life to the full, taking risks is part of it." The staff team recognised the importance of risk assessment and not taking away people's rights to take day to day risks. With support from staff, people were supported to go out with family and take part in activities. Staff recognised the importance of respecting and promoting people's right to take controlled risk and freedom of expression.

Staff had an understanding of abuse and what action they would take if they had any concerns. They identified the correct safeguarding and whistleblowing procedures should they suspect abuse had taken place, in line with the provider's policy. They were aware that a referral to an agency, such as the local authority, could be made. One staff member told us, "I would always tell the manager if I thought someone I was looking after was at risk. I'm sure they would do something but if they didn't, I'd let the local authority know." Another staff member said, "I would not hesitate to report anything that wasn't right." Staff confirmed the registered manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence. The registered manager said all concerns were reported to the local authority, they then waited for a response before they took any action and records were in place to support this. This meant people were protected as far as possible from abuse.

Sufficient numbers of skilled and experienced staff contributed to the safety of people who lived at the home. Staff arrangements included separate staffing on a daily basis for each floor. This was based on the skills and competency of staff and the individual needs of people. For example, each shift on the dementia and residential unit required a senior carer with competency in medicines. The nursing unit on the first floor had a registered nurse to oversee and monitor the clinical care provided. People told us there were enough staff to respond to their needs although they were often 'busy.' We were told, "Really lovely staff, always a smile, they sometimes seem very busy but they always give first rate care." Another person said, "Some days staff seem to be under the pressure but I have never had a worry about there not being enough staff."

We observed people received care in a timely manner and call bells were answered promptly. The registered manager undertook random audits on call bell response times. Staff told us that they worked hard to ensure an immediate response and felt the number of staff on duty allowed them to do so. Staffing levels allowed for staff to support people and to take people into the garden for fresh air. We also saw that staff sat with people in the communal areas chatting and engaging them with different activities whilst other people started to join them.

Recruitment processes were safe. There was a recruitment procedure in place. We found staff records included application forms, confirmation of identity and of the person's right to work. The recruitment process included a thorough interview and the sourcing of references that informed the provider of staff suitability. Each member of staff had a disclosure and barring checks (DBS) completed by the provider.

These checks identify if prospective staff had a criminal record or were barred from working with children or adults at risk. There were systems in place to ensure staff working as registered nurses had a current registration with nursing midwifery council (NMC) which confirms their right to practice as a registered nurse.

People were cared for in an environment that was safe. There were procedures in place for regular maintenance checks of equipment such as the lift, fire fighting equipment, lifting and moving and handling equipment (hoists). Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Health and safety checks had been undertaken to ensure safe management of food hygiene, hazardous substances, staff safety and welfare. People had personal emergency evacuation plans (PEEPs) which detailed their needs should there be a need to evacuate in an emergency. Staff had received regular fire training and evacuation training. Staff told us they felt confident they would be able to manage an emergency situation and talked of the organisational on call systems in place.

Good

Is the service effective?

Our findings

People and relatives had confidence in the skills and abilities of the staff employed at Lauriston. One person told us, "They have made me feel so much better," another person said, "I think all the staff are highly trained, they seem very knowledgeable." One visitor said, "The staff are all very good, they all know exactly how to respond to X and get the best results." Feedback from visiting health care professionals was positive about the skills and competence of the staff and their willingness to learn. People were complimentary about the food and how they were provided with choice and variety.

The management team organised all staff training and worked with staff regularly to underpin what was needed in the training sessions. These sessions contributed towards staff supervisions by giving staff and the registered manager an opportunity to share and reflect on their practise. Staff received training in safeguarding, food hygiene, fire evacuation, health and safety and infection control. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were competent to work unsupervised. Staff also received additional training specific to peoples' needs, for example care of catheters percutaneous endoscopic gastrostomy (PEG), dementia care and end of life care provided by the local hospice. Additionally, there were opportunities for staff to complete further accredited training such as the Diploma in Health and Social Care. One member of staff said, "All the staff get training. I have completed a National Vocational Qualification in Care -Level 2 and 3. We all complete mandatory training." From talking with staff we found that they were committed to learning and wanted to develop the dementia care further. One staff member said, "They are so special our residents, they deserve the best we can do, anything we can learn is good for them."

We saw staff used their training to assist them in their roles within the home. For example, we observed staff assisting people with their meals in a way that ensured they were maximizing their independence, but assisting discretely. We also observed people moving people safely throughout the inspections in hoists and wheelchairs. We saw staff communicate with people by using different techniques displaying empathy and patience.

Staff received on-going support and professional development to assist them to develop in their roles. Supervision schedules and staff we spoke with confirmed they received supervision and appreciated the opportunity to discuss their role and any concerns. Feedback from staff and the manager confirmed that formal systems of staff development, including an annual appraisal was undertaken. The registered manager told us, "It's important to develop all staff as it keeps them up to date, committed and interested." Staff told us that they felt supported and enjoyed the training they received. Comments included, "Interesting", "Valuable" and, "The RN (registered nurse) works with us on the floor to make sure we do things correctly."

People commented they felt able to make their own decisions and those decisions were respected by staff. Staff understood the principles of the Mental Capacity Act (MCA) and gave us examples of how they would follow appropriate procedures in practice. There were also procedures in place to access professional assistance, should an assessment of capacity be required. Staff undertook a mental capacity assessment on

people admitted to the home and this was then regularly reviewed. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. There was evidence in individual files that best interest meetings had been held and enduring power of attorney consulted. During the inspection we heard staff ask people for their consent and agreement to care. For example, we heard the registered nurse say, "Are you ready for your medicine now, and have you any discomfort." Care staff asked people, "Shall I help you to the bathroom," and "Would you like another cup of tea." Staff were able to tell us that they know people's mental capacity can change quickly and so it was always important to approach people and ask for their consent.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). During the inspection, we saw that the registered manager had sought appropriate advice in respect of these changes in legislation and how they may affect the service. The manager knew how to make an application for consideration to deprive a person of their liberty, such as locked doors and had submitted applications where they were deemed necessary. We looked at the applications and saw that the reasons for applications were person specific and included a rationale.

People commented they regularly saw the GP and relatives felt staff were effective in responding to people's changing needs. One relative told us, "The staff know what they are doing, everybody is involved in the care as well as doctors." Staff recognised people's health needs could change rapidly and some people may not be able to communicate if they felt unwell. One staff member told us, "We look for little signs, changes in behaviour, strong smelling urine and facial expressions which may indicate something is wrong. We then seek advice from the GP or specialist team." People told us they had access to chiropodists, dentists, dieticians, opticians and psychologists. People were also supported with attending appointments.

Records and discussion with staff confirmed that staff had developed links to communicate effectively and co-ordinate a multi-disciplinary approach to care. For example, specialist tissue viability nurses were contacted and involved in planning and reviewing of care for people who had skin damage. Specialist advice was also sought from dementia care specialists who supported staff in providing tailored support to people who could exhibit behaviour that may challenge staff and other people. Staff demonstrated professionalism and a commitment to providing the best care possible working in conjunction with all additional health care professionals available.

People told us the food was good and we saw staff asked them what they wanted at mealtimes and offered drinks in between. One person said, "The food is good, lots of choice, we can have seconds." People had an initial nutritional assessment completed on admission and their dietary needs and preferences were recorded. People told us that their favourite foods were always available, "They know what I like and don't like and there is always a choice." A nurse told us, "People have a nutritional assessment when they arrive. We can cater for diabetic, vegan, soft or pureed and any other special diets. We don't have any cultural preferences at the moment but the chef would be able to meet any dietary requirement."

People's weight was regularly monitored and documented in their care plan. Some people didn't wish to be weighed and this was respected, and staff said, "We use different ways to monitor their weight such as clothing if they don't want to be weighed." The registered manager said, "The kitchen staff and staff talk daily about people's requirements, and there is regular liaison with Speech and Language Therapists (SALT) and GP." The staff we spoke with understood people's dietary requirements and how to support them to stay healthy. The chef told us staff kept the kitchen informed of any changes to peoples' dietary needs and also told the kitchen staff of people who needed their food fortified.

Lauriston provided care and support to people with swallowing difficulties, for example following a stroke.

For people assessed with a swallowing difficulty, the use of thickened fluids when drinking was required to minimise the risk of choking and aspiration as thickened fluids are easier to swallow. However, the quantity and texture must be appropriate for the individual as otherwise they can place the person at risk of aspiration. Nursing and senior care staff were responsible for the management of thickened fluids and guidance was in place on the required texture of thickened fluids. The use of special shakers with written guidance on the shaker ensured that the thickened fluids were of the correct consistency for that person. Input from dieticians and speech and language therapists were also sourced. Guidance was readily available in people's care plans about any special dietary requirements such as a soft diet. One person's care plan had a report which identified they required a 'soft, moist diet'. We saw that this was followed. Staff informed us that this person was eating very little and their food intake chart reflected this. Staff told us of various ways they fortified people's food, "We use cream for soups and add cream to sauces, we make milk shakes as well."

Good

Is the service caring?

Our findings

The home had a relaxed atmosphere and people responded positively when staff approached them in a kind and respectful way. People nodded and smiled when asked if staff were kind and caring. Relatives felt staff offered the care and support people needed and wanted. One relative thought the staff were, "Wonderful, kind and patient" and, "Always cheerful and ready with a smile." One person told us staff didn't try and rush them to get everything done. One staff member said, "I feel that our staff team is really focussed on caring, we have all learnt and really want to do our best."

People were treated with kindness and respect, as individuals, and it was clear from our observations that staff knew people very well. Staff made eye to eye contact as they spoke quietly with people; they used their preferred names and took time to listen to them. Staff knocked on people's bedroom doors before they entered, saying, "Morning (name)" and, "How are you today." We saw several lovely interactions, staff used affectionate terms of address and gentle physical contact as they supported people, and people responded with smiles. We also saw a care staff member sit with a person during a late breakfast and encourage them with eating independently with gentle prompting, "Can I help or are you managing ok ?" and, "Let me help you with that." This enabled the person to retain their dignity whilst accepting help. The SOFI told us that staff and people engaged positively using verbal and non-verbal communication. During the meal service staff sat alongside people and maintained eye contact whilst assisting people. The pace that staff assisted people was set by the person and not the staff member, which meant that the person was not rushed and enjoyed their meal.

People were consulted with and encouraged to make decisions about their care. They also told us they felt listened to. A relative told us, "They ask us for suggestions and keep us well informed." Staff supported people and encouraged them where they were able to be as independent as possible. Another relative said, "X (name) doesn't have capacity to make decisions, but the staff encourage her to make choices." The registered manager told us, "People are supported to do what they want when they want."

Staff promoted people's independence and encouraged them to make choices. We saw that those people who liked to move around independently were supported discretely by staff. Staff talked to people and asked them if they needed assistance, they explained to people what they were going to do before they provided support and waited patiently while people responded. One staff member said, "Shall I help you to the table, its lunchtime soon." They leant down to talk to the person face to face so they could see their expression, and waited until the person responded. Comments from staff included, "We encourage people to be independent as they can be. We give them space and respect their independence" and, "We let people to make their own decisions if they can. For example, if someone doesn't want to do something then we make sure we offer later." Some people were able to confirm that staff involved them in making decisions on a daily basis. One person said, "I can choose to have breakfast in bed or in the dining area. Staff always ask me." Another person said, "Due to my health I spend a lot of time in bed, but staff do what they can to relieve my frustration, they pop in all the time and ask me if there is anything I need."

People's preferences were recorded in the care plans and staff had a good understanding of these. There

was information about each person's life, with details of people who were important to them, how they spent their time before moving into the home, such as looking after their family or employment, hobbies and interests. Staff said they had read the care plans and told us each person was different; they had their own personality and made their own choices, some liked music and noise while others liked to sit quietly, and they enabled people to do this as much as possible. People chose how and where they spent their time. People, who wanted to sit and read, rather than participate in activities, were supported to do so.

People's privacy and dignity was protected when staff helped them with personal care and bedroom doors remained closed as people were assisted to wash and get up. Staff told us, "People need a lot of support with their personal care and we keep in mind at all times that some things are very private. We would not like everyone to know that we had had an accident and our clothes were wet and needed changing. We just need to imagine how we would feel if it was us or a relative." This showed staff understood the importance of privacy and dignity when providing support and care.

People's equality and diversity needs were respected and staff were aware of what was important to people. People were encouraged to be themselves. One person said, "I know that I can express myself and staff will support me." Another person liked to look smart and told us staff ensured that their clothes were clean and pressed, we were also told"I like to wear make-up especially if I am going out, I can't do it myself but staff help me."

Staff said relatives and friends could visit at any time and relatives told us they were always made to feel very welcome. One relative told us, "We are always welcomed and feel at home, tea is always offered. We know all of the staff."

There were individual communal areas on all three units, these included lounges and dining areas and they were comfortable and provided the feel of being at home. Books, videos and DVDs were displayed for people to use at any time. People were seen enjoying spending time in different areas with family and friends. Outside areas were available and assessable for everyone. There were areas for people to be involved in growing vegetables and flowers and to sit and enjoy the fresh air.

There were people at the Lauriston who were receiving end of life care. End of life care is when people had been seen by a doctor who agreed to withdraw active treatment and according to their care plan, were to receive 'tender loving care' (TLC). TLC is used in care to describe considerate and solicitous care. Documentation to support this decision was in place and followed NICE guidance. NICE guidelines are evidence-based recommendations for health and care in England. This meant that this care pathway had been discussed, documented and agreed by families and health professionals involved in their care. We also saw that care plans for end of life care delivery included personal care, mouth care and detailed pain control management. Staff had received training in end of life care and the management of pain medicines. We found staff had a good understanding of how to monitor and manage pain relief at this stage of people's life.

Care records were stored securely in the staff offices. Information was kept confidentially and there were policies and procedures to protect people's confidentiality. Staff had a good understanding of privacy and confidentiality and had received training.

People were able to express their views and were involved in making decisions about their care and support and the running of the home. Residents' meetings were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. We saw that ideas and suggestions were taken forward and acted on. For example, menus, information on the use of advocacy services was

available and the registered manager confirmed the home worked in partnership with Independent Mental Capacity Advocates (IMCA) when required.

Good

Is the service responsive?

Our findings

People liked their rooms and had individualised them to suit themselves with memorabilia, photographs and personal possessions with the assistance of relatives and friends. Relatives said they were involved in discussions about and the planning of people's care and felt able to talk to the staff about this at any time. One relative said, "I know there is a care plan and I get asked regularly for my input." Another relative said, "I am informed of any changes and if my relative is unwell the staff ring me."

Staff undertook care that was suited to people's individual needs and preferences. People's needs had been assessed before they moved into the home and staff had reviewed this information and updated it with the help of relatives, friends and representatives. The care delivery was person specific and in line with people's preferences. For example, what they preferred to eat and drink, what time they got up and what time they returned to bed. For people unable to tell staff their preferences we saw that staff had spoken with families and friends. Staff told us, "People change and we adapt their care accordingly with help from family, friends and our staff."

Each care plan looked at the person's individual needs, the outcomes the support and care aimed to achieve and the action staff had taken to achieve this. For example, one person's need was assistance with mobility. The outcome was for staff to ensure their walking aids were always near them and that their footwear was correctly fitted for maximum support. We saw that staff followed these care directives and they were seen walking around the home. Another person who lived with diabetes had guidance within their care plan of how to respond if their normal blood sugar varied and what action to take. For example, if their blood sugar was lower than their normal range, staff were to give a glass of milk or a biscuit and to retake their blood sugar. This meant that care delivery was responsive to people's individual needs.

Activities at Lauriston were planned and tailored to meet peoples' preferences and interests as much as possible. We were told that the format of activities may change on the day depending on who chose to attend and how many. A programme of events was displayed in the communal areas of the home. These included one to one sessions, quizzes, craft sessions and musical and film sessions. During our inspection we saw a number of activities taking place and enjoyed by people. There was a fruit kebab making session and staff ensured that people who were on a soft diet were able to participate in the making and then ensured it was safe for them to eat. A quiz session with a prize was a highlight for some people who proudly showed their prize to us. Due to delivery of flower arrangements an impromptu flower arranging session took place and we saw staff on the dementia unit sit and support people to arrange flowers in a way that they wished to. Praise and encouragement was done in a respectful manner and people were relaxed and enjoying this simple pleasure.

The activity team consisted of two co-ordinators and they had the support of staff and volunteers. The dementia unit had continued to be an area that staff were constantly contributing ideas to develop as staff gained knowledge and confidence in providing care for those who live with dementia. One senior care member said, "We are constantly looking at ways to engage with our residents and ensure that we give them as much mental and physical stimulation as possible." Another staff member said, "We have so much more

to offer now, there is lots of interactive objects that catch our residents eye and it stops a lot of frustration" and, "The new mural of the Eiffel Tower in the dining room has become a real talking point and one of our residents always sits next to it because it brings back happy memories." We saw tables in the corridors that displayed items to engage people as they went past, such as bright colour tubing as a visual stimulant. Magazines that reflected people's specific interests and past hobbies had been brought in and were left open to capture people's attention. We saw people actively engage with items and rummage boxes throughout our inspection. People who had previously been restless and agitated were now calm and interacting positively with staff. Dementia signage was in place and the unit was welcoming, safe and comfortable.

There was good interaction seen from staff as they supported people with activities throughout the home. We received positive comments from staff and visitors about activities and the one to one sessions being undertaken for people who preferred or needed to remain on bed rest or in their room. One staff member said, "We have worked so hard and it's a pleasure to come to work."

Regular staff and resident/family meetings are now being held and we saw that times of meetings were displayed details of suggestions and discussion points were recorded and actioned. For example, meal choices. the action plan included surveys and regular meetings with the chef.

A complaints procedure was in place and displayed in the reception area of the home and in other communal areas. People told us they felt confident in raising any concerns or making a complaint. One person told us, "Yes I know how to moan and make a complaint." Another said, "I would tell one of the staff and I know it would be taken seriously." Complaints were recorded and responded to as per the organisational policy. A complaints log is kept and monitored by the head office of Methodist Homes.

Good

Is the service well-led?

Our findings

From our discussions with relatives, staff, the registered manager, the provider and our observations, we found the culture at the home was open and relaxed. Care and support focused on providing the support people living at Lauriston needed and wanted. Relatives and staff said the registered manager was available and they could talk to them at any time. We observed the registered manager greeting and sitting with people and talking to them at various times throughout our inspection. Relatives said the management of the home was good and all staff were always very helpful. One relative said, "The home is well led, clean and calm."

Effective management and leadership was demonstrated in the home. The registered manager was keen and passionate about the home and the people who lived there. They told us that the philosophy and culture of the service was to make Lauriston 'Their home'. He also told us, "It's important that we make it comfortable, homely and safe. We give good care because we do care." The registered manager took an active role within the running of the home and had good knowledge of the staff and the people who lived there. There were clear lines of responsibility and accountability within the management structure. The culture of the service was described as open, honest and friendly by people and staff. The registered manager said their door was always open if staff wanted to have a chat with them. One member of staff said; "You're not going to get any better bosses. "Staff were happy to challenge poor practice if they saw it and would contact the registered manager or other senior staff immediately if they had any concerns.

Staff spoke of the home's vision and values which governed the ethos of the home. Displayed in areas of the home was a value statement that staff were proud of. The ethos of the home was embedded into how care was delivered and the commitment of staff to provide good quality care and person specific care. The manager and staff had a strong emphasis on recognising each person and their identity. Staff wanted to provide care that was individual to that person and it was clear staff recognised each person in their own entity. From observing staff interaction, it was clear staff had spent considerable time with each person, gaining an understanding of their life history, likes and dislikes. Care was personal to each person and staff clearly focused on the individual and their qualities.

Quality monitoring systems had been developed and sustained over the past year. There were a wide range of audits undertaken to monitor and develop the service and we looked at a selection of these. Audits were carried out in line with policies and procedures. Areas of concern had been identified and changes made so that quality of care was not compromised. Areas for improvement were on-going such as care documentation. The registered manager said it was an area that they wanted to continuously improve their recording. All care plans were up to date and reflective of people's needs. Where recommendations to improve practice had been suggested, from people, staff and visitors, they had been actioned. Such as laundry service and menu choices. Falls, accidents and incidents were recorded, monitored and an action plan put in place to prevent a re-occurrence. There were additional audit tools that looked at 'hot spots' of accidents/incidents in the premises. This consisted of a floor map and identified areas of the floors that needed further monitoring by staff. On discussion with the registered manager future actions of persistent falls may include looking at a more suitable room location for certain people. This would only happen if it is

in the best interest of the person. Medicine audits looked at record keeping and administration of medicines and the manager said action would be taken through the supervision process if issues were identified.

The management team had been working consistently to develop the support and care provided at the home. The manager said, "Whilst we feel we have really improved, we want to continue to improve to deliver really outstanding care." Staff were proud of the improvements they had made, the morale of staff was strong and they worked as a team.

Systems for communication for management purposes were established and included a daily meeting with the senior staff. These were used to update senior staff on all care issues and management messages. For example, discussion around who had fallen and what risks had been identified. Staff felt they could feed into these meetings. One staff member said, "The manager is open to suggestions, staff meetings give us the opportunity to raise issues and solve problems." Each shift change also had a handover meeting so staff changing shifts shared information on each person. A handover sheet given to staff facilitated this process with key aspects of care being recorded. Staff told us they were involved in discussions about people's needs and were encouraged to put forward suggestions and opinions during the daily meetings and the monthly staff meetings. Staff said, "We are encouraged to be involved in developing the service here." "I think the management is strong and approachable" and, "I feel sure that if I speak to the manager about anything, something will be done about it. I don't just mean complaints suggestions are encouraged as well and they listen to us."

The service worked in partnership with key organisations to support the care provided and worked to ensure an individual approach to care. Visiting health care professionals were positive about the way staff worked with them and this ensured advice and guidance was acted on by all staff. Comments received included, "The staff are knowledgeable about the people they care for, and want to get it right" and, "They listen, take advice and act on the advice."

Relatives felt they were able to talk to the manager and staff at any time and the relatives meetings provided an opportunity for them to discuss issues and concerns with other relatives, friends and management on a regular basis. One relative said, "If I have a problem I just talk to the staff or manager and they deal with it." The service had notified us of all significant events which had occurred in line with their legal obligations.