

Dolphin Homes Limited

The Laurels

Inspection report

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Ratings

Overall rating for this service	Good ●
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?	Good ●

Summary of findings

Overall summary

The inspection took place on the 25 April 2016. The inspection was unannounced.

Dolphin Homes, the provider, is a specialist care provider delivering care and support for adults with learning difficulties, behaviour which challenges others, physical disabilities and complex health needs, autism and Asperger's syndrome. The Laurels provides care and support for up to seven people with a learning disability and / or a physical disability. People's rooms were arranged over two floors with both stairs and a lift available to access the first floor. Each room had its own ensuite wet room. There was a bathroom, but this was not in use. Where necessary people's room were fitted with overhead hoists to assist with moving and handling tasks. In addition the home had a lounge and conservatory, a kitchen and separate dining room, a laundry and a staff office. The home had a large garden to the rear and parking to the front.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Although the people living at The Laurels were unable to communicate with us, we observed that they appeared relaxed and comfortable in the presence of the staff that were supporting them.

Care records included guidance for staff to safely support people. People had risk assessments and risk reduction measures were in place although we did note that body maps could be more effectively used to document and plan for how skin damage was responded to.

Arrangements were in place to help manage people's medicines safely, although we noted that medicines audits could be more effectively used to help identify administration errors and allow mitigating actions to be taken to prevent further errors.

Staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns to their management team.

Safe recruitment practices were followed and appropriate checks had been undertaken which made sure only suitable staff were employed to care for people in the home. There were sufficient numbers of experienced staff to meet people's needs.

Staff received a suitable induction which involved learning about the needs of people using the service and key policies and procedures. Staff were supported to provide appropriate care to people because they were trained, supervised and appraised.

The provider and registered manager understood their responsibilities with regards to the Mental Capacity Act (MCA) 2005 and improvements were underway which when embedded will ensure that mental capacity assessments are fully documented.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were either in place or had been applied for.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs and risks in relation to nutrition and hydration.

Staff had a good knowledge and understanding of the people they were supporting. Staff were able to give us detailed examples of people's likes and dislikes which demonstrated they knew them well.

People were supported to take part in a range of activities and make choices about how they spent their time.

Relatives and staff spoke positively about the registered manager. There was an open and transparent culture within the service and the engagement and involvement of people and staff was encouraged and their feedback was used to drive improvements. There were systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving the best possible support.

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

However, body maps could be more effectively used to document and plan for how skin damage was responded to and medicines audits used to help prevent further medicines related errors.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. Staff were clear about what they must do if they suspected abuse was taking place.

Staffing levels were adequate and enabled the delivery of care and support in line with peoples assessed needs. Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised.

Requires Improvement ●

Is the service effective?

The service was effective

The provider and registered manager understood their responsibilities with regards to the Mental Capacity Act (MCA) 2005 and improvements were underway which when embedded will ensure that mental capacity assessments are fully documented.

Staff were supported to provide appropriate care to people because they were trained, supervised and appraised.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs and risks in relation to nutrition and hydration.

Good ●

Is the service caring?

The service was caring.

Staff had developed positive relationships with the people they supported and had a good knowledge and understanding of their needs and of their likes and dislikes.

Good ●

People were treated with dignity and respect and were encouraged to live as independently as possible.

Is the service responsive?

The service was responsive.

People's care and support plans were personalised and their communication techniques and preferred daily routines were detailed throughout their care records. This supported staff to deliver responsive care.

People were supported to take part in a range of activities in line with their personal preferences.

Complaints policies and procedures were in place and were available in easy read formats.

Good ●

Is the service well-led?

The service was well led

There was an open and transparent culture within the service and the engagement and involvement of people and staff was encouraged and their feedback was used to drive improvements.

There were systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving the best possible support.

Good ●

The Laurels

Detailed findings

Background to this inspection

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

The inspection took place on the 25 April 2016 and was unannounced. The inspection team consisted of one inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is used by registered managers to tell us about important issues and events which have happened within the service. 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, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

Due to nature of the needs of people using the service, we were not able to seek their views about the care and support they received; however, we spent time observing interactions between people and the staff supporting them. We also spoke three relatives, the registered manager, the area manager and three support workers. We reviewed the care records of two people in detail. We viewed the medicine administration records for all seven people. Other records relating the management of the service such as audits and policies and procedures were also viewed.

Following the inspection we sought feedback from four health and social professionals about the quality of care people received.

The last full inspection of this service was in December 2013 when no concerns were found in the areas inspected.

Is the service safe?

Our findings

People were unable to tell if they felt safe living at The Laurels, however our observations indicated that they felt relaxed and comfortable in the presence of their care workers and responded positively when staff approached them or offered them support.

Assessments were undertaken to identify risks to people's wellbeing. For example, we saw that nutritional risk assessments were in place which helped to identify whether people were at risk of dehydration or weight loss. Where risks had been identified, staff were provided with guidance which helped to ensure that the risk was minimised. For example, one person's support plan contained information about the signs and symptoms they might display if an infection was developing. People had risk assessments in relation to their personal care, accessing the community, moving and handling and financial matters. Staff were informed about each person's risks and were able to describe the strategies in place to manage these. For example, staff described the interventions they used to help calm or de-escalate behaviours displayed by one person. Monitors were used to alert staff if people were experiencing a seizure whilst in bed. Staff told us that clocks were available in each person's rooms or on the backs of their wheelchairs so that they could monitor the length of seizures and if necessary administer emergency medicines. This helped to ensure that risks to people's health and welfare were managed effectively. One person who was at risk of developing pressure areas had a number of body maps which documented a variety of skin damage. It was not always clear what actions had been taken in response. This is an area which could improve. The registered manager told us they would explore with the provider whether the body map form could be revised to ensure it prompted staff to record what might have caused the bruising and the actions taken in response. This is important to help prevent deterioration. Also any unexplained skin damage could indicate a safeguarding concern and require an alert to be raised with the local authority.

Staff were able to share with us examples of positive risk taking and there was evidence that staff did not restrict people's interests. For example, one person could at times display self-injurious behaviour. Staff told us the person was still encouraged to take part in cooking and using knives although this was with the close support of staff using hand over hand techniques to reduce any risks to the person. Risk assessments identified that people were at increased risk of being disempowered due to their lack of verbal communication, or of not having their consent sought and choices respected. Staff were guided to ensure they treated the people they supported with dignity and as an individual. We saw that staff provided support in a manner that was in keeping with this guidance.

There were systems in place to protect people from risks associated with the environment. Six of the people living at the service had personal emergency evacuation plans (PEEPS) which detailed the assistance they would require for safe evacuation of their home. The PEEP for the seventh person who had recently moved into the home was being developed during the inspection. The provider was developing a business continuity plan which when fully completed would set out how the needs of people would be met in the event of the building becoming uninhabitable or an emergency such as a fire or flood and contain essential contact emergency contact numbers.

Improvements were needed to how some aspects of people's medicines were managed. Staff who administered medicines had completed training and underwent annual competency assessments. Medicines were kept safely in locked cabinets and a trolley in a medicines room. However, when we looked inside the medicines trolley, although well ordered it was dirty. We also found that staff had not recorded the date of opening on two bottles of medicines. Recording this information is important because if medicines have been opened for longer than recommended, they may not be safe to use or can lose some or all of their effectiveness. We reviewed seven people's medicines administration record (MAR). These contained sufficient information to ensure the safe administration of medicines. We did note that there was one gap in a person's MAR which we brought to the attention of the registered manager. We also noted from reviewing the incident records that the service had experienced a number of medicines related incidents. We were aware that each day the shift leader audited people's MARS to ensure that people had received their medicines as prescribed; however, this was not identified the gap in the MAR we had found. We were concerned therefore that the audit system was not yet being fully effective at preventing medicines related errors.

The temperature of the fridges and rooms used for storing medicines were being monitored daily. Storing medicines within recommended temperatures is important as this ensures that they are safe to use and remain effective. There were protocols in place for the use of 'as required' or PRN medicines. These included information about the strength of the drug and the maximum dose to be given in 24 hours. Where the PRN medicines were for pain relief, the protocols included some information about the signs or behaviours which might indicate that the person was in pain. Similar PRN protocols were in place for the use of medicines which managed people's agitation or anxiety. Staff told us the circumstances in which they would administer these medicines; this was in line with the guidance contained within the protocols. Some people required rescue medicines to help manage their epilepsy. Protocols were in place for the use of these medicines and staff had received specific training to administer these safely.

We carried out a stock check of Controlled drugs. Controlled drugs (CD's) are medicines which are controlled under the Misuse of Drugs Act 1971 and which require special storage, recording and administration procedures. We undertook a balance check of the controlled drugs held in the CD cupboard against the register and these agreed.

We discussed our findings with the registered manager. They took immediate action to ensure the medicines trolley was cleaned. They told us the gap in the person's MAR would be investigated and where necessary additional training would be provided to staff members. The registered manager and area manager also told us that further work was planned with the staff team to reduce the number of medicines errors and to ensure that medicines audits were be more effectively used to drive improvements.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. The organisation had appropriate policies and procedures and information was available on the local multi-agency procedures for reporting abuse. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. Staff told us they were aware of how to report concerns about poor practice which is often known as whistleblowing. They were also aware of other organisations with which they could share concerns about abuse or poor practice.

Staffing levels were adequate. During the day the usual staffing levels were five support workers to care for the seven people using the service. At night there were two waking night staff. The registered manager told us that the staffing levels were determined by people's needs and were adjusted as required to ensure people had the support they needed to undertake specific activities. For example, most people required one

to one support whilst in the community and so staffing levels were adjusted to take account of this. All of the staff we spoke with told us the staffing levels were adequate. One staff member said, "I am very happy with the staffing levels, there is always enough and if there is not, cover is arranged". Our observations during the inspection indicated that the staffing levels enabled people's needs to be met in a safe manner. A social care professional told us, "My client requires one to one staffing; there have not been any incidents where their shifts were not covered. Their family express satisfaction with the small staff team, agency and bank staff are avoided".

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. These included identity checks, obtaining appropriate references and Disclosure and Barring Service checks. Staff were required to undertake two interviews which were competency based and sought to gain an understanding of how caring the person was and how they might respond to safeguarding concerns for example. The second interview took place at the service and involved observing how the prospective staff member interacted with people using the service. These measures helped to ensure that only suitable staff were employed to support people in their homes.

Is the service effective?

Our findings

People were supported by staff that had a good knowledge of their needs and during our inspection we observed that staff delivered care effectively and to an appropriate standard. We observed staff working in a professional manner and communicating with people effectively according to their needs. Feedback from health and social care professionals indicated they felt the home provided effective care. A social care professional told us, "Staff, particularly the manager, appear to have a good understanding of the client's needs, risks and wishes. The service has good links with the local health teams and refers appropriately".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The need to act in accordance with people's consent and choices was clearly referenced throughout their support plans. Where people used specific communication techniques to indicate their choices, these were described. We saw that staff used these techniques effectively to help people make decisions about what drink they would like and which DVD they would like to watch.

Where people were unable to make decisions about their care, staff were guided by the principles of the Mental Capacity Act (MCA) 2005. Staff were aware that decisions made on behalf of people must be in their best interests and made in consultation in relevant persons, however the assessment and decision making process had not always been fully documented. The registered manager showed us that they were introducing a new mental capacity toolkit to help ensure that they and staff were able to fully document what decisions had been reached in the person's best interests and who had been involved in this process. This process once embedded will help to ensure that the staff are fully implementing the Mental Capacity Act 2005.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Relevant applications for a DoLS were either in place or had been submitted by the home.

New staff received a five day induction at the providers head office which involved completing a range of essential training and learning about key policies and procedures. A member of staff told us that following this they had completed another period of induction within the service, shadowing more experienced staff and learning about people's needs and routines. The induction staff completed was mapped to the Care Certificate which was introduced in April 2015. The care certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. A member of staff told us, "The induction was really good, even though I had a NVQ 3; I learnt something new every day".

Staff completed a range of essential training. This was all delivered face to face by the provider's in house

trainer or by external professionals. The training completed included, moving and handling, person centred care, first aid, safeguarding people, fire safety, food hygiene, MCA 2005 and infection control. Staff also completed training in how to use positive strategies to intervene in the event of a crisis to de-escalate behaviour which might challenge others. Additional training relevant to the needs of people using the service was also completed, for example, staff had completed training in epilepsy, using and caring for specialist feeding devices and caring for people living with autism. A training plan was on display in the office and showed the dates of future training and when staff were required to complete refresher training. Staff told us they were supported to undertake additional training or qualifications where necessary. One care worker told us they had asked to complete training in Makaton and this had been arranged for May 2016. Makaton uses signs and symbols to help people communicate. Staff were positive about the training available and told us it helped them to perform their role effectively.

Support for staff was achieved through individual supervision sessions and an annual appraisal. Staff told us they received regular supervision which was useful in measuring their own development and additional training needs. A member of staff said, "We have supervision every six to eight weeks, it's useful, if there is an issue in between, you can ask [the registered manager] and they will meet with you straight away".

People were supported to have enough to eat and drink and their care plans included information about their dietary needs and risks in relation to nutrition and hydration. Staff demonstrated a good understanding of these specific needs and were able to clearly describe how these were catered for. Staff were aware for example, which people required a pureed diet and which could tolerate a soft or mashed diet. Information about people's dietary requirements and allergies was displayed in the kitchen. Some people obtained their main source of nutrition via an artificial feeding device, however in line with professional guidance; staff supported these people to also have some meals so that so they could still enjoy the taste and texture of food. People were involved in decisions about what they ate and staff told us that each week, they all sat down together and planned the weekly menu. Staff took the lead in cooking meals but said that they encouraged people to get involved as much as possible. On the day of our inspection, people were enjoying a range of foods for lunch which included a ready prepared pureed meal from a meal delivery service which we saw had been presented in an appropriate and appealing manner. Other people were enjoying finger foods and sandwiches. Records were maintained of what each person ate and these showed that people were being supported to maintain a varied diet. We saw that people had access to adapted cutlery which enabled them to remain as independent as possible with eating and drinking.

Where necessary staff had worked effectively with a range of other healthcare professionals to help ensure that people's health care needs were met. This included GP's, community learning disability nurses, speech and language therapists, physiotherapists, behavioural support specialists, community nurses, dentists and opticians. For example, we saw that staff had consulted with one person's doctor when they had noticed that they were showing signs of increasing thirst. People had health action plans (HAP). A HAP holds information about an individual's health needs, the professionals who are involved to support those needs and hospital and other relevant appointments.

Is the service caring?

Our findings

People living at The Laurels were not able to tell us how caring the service was and so we spent time observing whether they were treated with kindness and their dignity and privacy was respected. Our observations indicated that staff showed people kindness, patience and respect and offered people lots of praise and gentle encouragement to complete a task or chore. The Staff team were cheerful and motivating, for example, at lunch time, we watched a care worker supporting one person to eat and drink. We heard them say to the person, "Go on, you try". The atmosphere was positive and it was clear that staff had developed a meaningful relationship with each person and that they in turn had trust and confidence in the staff supporting them. Staff demonstrated an inclusive approach to the care and support provided with each person being treated as a unique person. Staff told us that this was highlighted by a tree painted on the wall in the lounge which had photographs of each person using the service displayed amongst its branches. The message below the tree was 'Ohana which means family, family means that no-one gets left behind'. Staff told us this was how they felt about their work at the home. One staff member told us, "I love it here, I really enjoy it, I love the challenge, the difference you can make to people, seeing them happy is important, it doesn't matter what it takes". A relative told us, "They are all lovely staff, the atmosphere is lovely, there is a lot of happiness and laughter, and I feel very fortunate [their relative] is there, they love them to bits". A social care professional told us, "The [people using the service] present as relaxed at 'home' and have a good rapport with the care staff. Staff interact appropriately with [people using the service], prompting them to make choices within their abilities".

Staff showed they had a good knowledge and understanding of the people they were supporting. People had key workers who worked closely with the person so that they became very familiar with their needs and wishes. Staff were able to give us detailed examples of people's likes and dislikes which demonstrated that they knew them well. We were given examples of the types of food people liked to eat and what activities they enjoyed as well as their preferred daily routines. For example, staff told us that one person liked to spend quiet time in the conservatory listening to music, we saw that they were supported to do this. This information was also reflected in people's care plans. A staff member told us that one person who enjoyed football had been supported to go to a football match at the weekend which they had greatly enjoyed. We saw that staff had taken a number of photographs of the day and used these to chat with the person about the day, trying to relive the experience for them.

The registered manager and staff told us that the people who used the service were involved in planning their care and support as much as possible. Meetings were held with people on a weekly basis and were an opportunity for them to make choices as able about their meals for the week and the activities they wanted to take part in. Staff told us how they tried to involve people in making choices about what they wore each day. Staff communicated with people in a person centred manner. Most of the people using the service required wheelchairs; we saw that when staff talked to them, they ensured they were at the person's level and not standing over them. We saw that there was a range of communication flash cards available for staff to use to assist people to be involved in decisions about their care. On the day after our inspection, one person was being visited by a specialist team to assist in developing further communication aids. These measures helped to ensure that people had the opportunity to express their views with appropriate support

from staff.

People were encouraged to maintain relationships with their family and to make new friends through visiting the providers other homes nearby. Relatives were welcomed at the home or people were supported to visit them in their own home. Where people did not have close family or visitors we were told that staff advocated on their behalf. For example, a social care professional told us that staff had advocated very strongly on behalf of one person whom they believed was being discharged from hospital too soon. This resulted in a more positive outcome of the person as they were then found to have an undiagnosed infection. Where required we saw that staff also made referrals to formal advocacy services to ensure that people had every opportunity to express their choices and wishes.

Staff told us how they supported people in a way that maintained their independence. One staff member said, "[person] can be a danger with knives and forks but we encourage them to eat and drink independently, but monitor it carefully". They also explained how two people were encouraged to walk at times rather than use their wheelchair so that their mobility was maintained as much as possible.

Our observations indicated that staff provided care in a manner which was respectful of people's dignity and privacy. We saw staff knocking on people's doors before they entered their rooms. Some people required their medicines to be administered via their artificial devices, where this was the case, staff ensured this was completed in private to protect the person's dignity. People's care plans were written in a manner that encouraged staff to be mindful of people's dignity. People had an equality and diversity support plan which described how staff should ensure they spoke to people 'as an adult' and to be mindful of the person's 'right to be treated with dignity'. People's personal care support plans reminded staff to cover people with towels to maintain their dignity. Staff told us how they ensured people's doors were shut when personal care was taking place and that the signs of people's doors were used to confirm this.

Is the service responsive?

Our findings

People's support plans were personalised and their preferences and choices were detailed throughout their care records. This supported staff to deliver responsive care. Each person had a detailed support plan which contained information about them as a person, their daily routines, their needs, how they communicated and what aspects of their behaviour might mean. For example, one person's plan described how they were 'fun bubbly person who was mischievous and enjoyed a joke'. They disliked being rushed and ignored or spending too much time indoors. We were able to see that if they were crying, this always meant something was wrong and therefore a response from staff was needed. The support plan provided detailed guidance about how staff should meet the person's care needs. Another person's support plan contained detailed information about the potential triggers for self-injurious behaviour and the strategies staff could use to de-escalate these. The support plans had been developed with input from the person's families and the health and social care professionals involved in their support. Staff told us they could refer to people's care plans in order to understand their needs and it was evident that the care plans had been read by staff. A social care professional told us, "Staff are responsive to [people's] needs and intervene appropriately". This helped to ensure staff understood the needs of the people they supported and enabled them to care for them in a personalised manner.

People also had key worker folders which contained further information about the person and their lives before coming to live at the service. For example we saw that one person's folder contained lots of photographs of the person growing up with their family. There was information about their preferred activities and we were able to see that they had been supported to take part in these which included ice skating. Staff maintained daily records which were mostly detailed and noted how the person had been, what they had eaten and what activities they had been involved in. This helped to ensure that staff were able to effectively monitor aspects of the care and support people received. When concerns were noted about a person's health or behaviour, staff had responded by making referral to relevant healthcare professionals. A staff member told us how they had noted that a change in one person's medicines had had a negative impact on their mobility and so they had requested the GP review this following this the new medicine was stopped. A social care professional told us, "The Laurels monitor symptoms and communicate changes to appropriate professionals".

People regularly took part in a range of activities. Within the home, people were involved in activities such as painting, cooking and watching DVD's, listening to music or spending quiet time in their rooms. Outside the home, they visited a variety of places including a sensory centre, a hydrotherapy pool and the cinema. Some people attended local day centres, whilst other went out for trips either in their own cars for the homes mini bus. We also saw that people had taken part in wheelchair ice skating, trips to local museums, the new forest, Monkey world and a local sea life centre. A relative told us that their love one had been supported to go on a holiday to Blackpool which they had thoroughly enjoyed. A member of staff told us, "They get out more than me, we vary where we take them, we took [the person] to the football at the weekend, they loved it, they are seeing places I've never seen".

People, the relatives and staff were asked for their views about the service. Three times a year, the provider organised a service user forum. This was an opportunity for people to get together and discuss issues about their care and make suggestions about how the service might improve. Annual surveys were completed with

relatives and staff, the responses were analysed and an action plan drafted to address any areas for improvement. In the most recent survey staff had identified that the décor and maintenance of the home could improve. The area manager told us that in response the home had been decorated throughout. The area manager told us that a relative had fed back in a survey that they would like their loved one to have a holiday; we saw that this had been facilitated. Staff meetings were held on a regular basis and were an opportunity to discuss issues with the manager and the rest of the team. One staff member said, "The manager listens to what we have to say" and another said, "You ask [the registered manager] and they do it straight away".

Complaints policies and procedures were in place and were displayed in communal areas in easy read formats. There were arrangements in place to record complaints that had been raised and what action had been taken about resolving the issues of concern. This helped to drive improvements. Relatives told us they had were confident that they could raise concerns or complaints and that these would be dealt with. There had not been any formal complaints within the last 12 months, although the service had received a number of compliments about the care they provided and feedback from the relatives we spoke with was positive about the service.

Is the service well-led?

Our findings

Relatives told us that the home was well led. One relative said, "I can't fault them, especially since [the registered manager] came, she's brilliant". Another relative told us the registered manager did a "Brilliant Job". A social care professional also told us the service was well led. They said, "The manager has kept me fully informed with significant changes...where there have been issues, the Laurels informed relevant parties, made appropriate arrangements and ensured the issue was resolved in a timely way". Staff were positive about the leadership of the service, their comments included, "This is the best place I have worked, It's a pleasure coming to work the registered manager is always on the floor, they come out on trips, they are very hands on".

There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure that people were receiving the best possible support. The provider undertook regular visits to the service to check on the quality of care being provided and the safety of aspects of the service. Reports were produced as a result of these visits and if any areas for improvement were identified, the manager was provided with a 'corrective action report' which detailed the actions needed to address the shortfall. We viewed three such reports that had been produced in response to a provider audit and found that the required actions had all been completed.

Staff completed a range of health and safety checks to help identify any risks or concerns in relation to the environment and equipment used for delivering people's care. Monthly checks were undertaken of the fire alarm system and exits, water temperatures and equipment such as wheelchairs and slings and the lift had been serviced in April 2016. The area manager told us that an external company were shortly updating the Legionella risk assessment.

Where deficiencies were noted, maintenance requests were completed in a timely manner. The registered manager undertook monthly checks of people's support plans to ensure they were accurate and up to date. The service had systems in place to report, investigate and learn from incidents and accidents. All incident forms were reviewed by the registered manager to enable trends to be picked up and addressed so as to stop a similar incident happening again. The manager had submitted notifications to CQC appropriately of incidents which had happened at the service and any safeguarding concerns raised. This all helped to ensure that robust systems were in place to monitor and improve quality and safety within the service.

The registered manager was in the home most days and they demonstrated a good understanding of all aspects of the home and the needs of people living there. A staff member told us that one of the things that worked well was that the management team and provider worked well with commissioners to ensure that robust decisions were made about which people to admit to the home. This helped to ensure that the persons needs could be met and limited to risk of any negative impact on those already living at the home.

The registered manager had created an open and transparent culture with the staff team, staff told us they felt confident going to the manager with any concerns or ideas and they felt that the manager would listen and take action. The culture within the home focused upon supporting people to receive the care and

support they required to have a happy and comfortable life. All of the staff we spoke with were committed to providing a high standard of person centred care and support and were proud of the job they did. Staff clearly enjoyed their work and told us that they received regular support from their manager and that morale amongst the staff team was good.