Dolphin Homes Limited

The Laurels

Inspection report

1 Lower St Helens Road
Hedge End
Hampshire
SO30 0NA

Tel: 01489799119
Website: www.dolphinhomes.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Dolphin Homes, the provider, delivers 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 complex health needs and a learning disability and / or a physical disability.

People in care homes receive accommodation and their care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection. This inspection took place on 7 and 9 January 2019 when there were seven people using the service.

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 2008 and associated Regulations about how the service is run.

The Laurels had been developed and designed in line with the values that underpin
Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities using the service lived as ordinary a life as any citizen. People were given choices and their independence and participation within the local community was being encouraged and enabled.

At our last inspection we rated the service as overall good. At this inspection, we found some areas where improvements were needed and one breach of the fundamental standards. We have now rated the service as requires improvement.

The provider's governance and quality assurance systems were not being fully effective at monitoring the quality and safety of the service. We found a number of areas where records relating to people's care, and to the management of the service, were not complete, accurate and up to date.

Where people were unable to make more complex decisions about their care and support, staff had not always demonstrated how they were acting in accordance with the MCA 2005.

Whilst staff knew how to support people in a way that minimised identified risks, records relating to this were not always accurate. Similar concerns were found in relation to medicines records. We were concerned this could impact on people's safety.

Overall, the design and layout of the premises met people's needs, but further action was needed to ensure that all aspects of the premises were well maintained and in a good state of repair.

There were sufficient numbers of staff to meet people's needs.

Staff followed infection control guidance and the home was visibly clean.

Incidents and accidents were investigated and remedial actions taken in response.

Health and safety checks were carried out to ensure the safety of the building and equipment within it, but we have made a recommendation about window restrictors.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect.

Staff understood their responsibility to raise concerns and report on incidents and accidents.

Staff received the training and support they required to meet people's individual needs. Staff worked well with external health care professionals and people were supported to access health services when required.

People were treated with dignity and respect and staff were kind and caring in their interactions with people. People received care that was centred on them as an individual.

People were supported to follow their interests and take part in social activities both within the home and within the community.

Relatives were confident they could raise concerns or complaints and these would be dealt with.

We have made a recommendation about developing end of life support planning for people using the service.

Relatives and staff expressed confidence in the registered manager and their ability to manage the home well. Everyone continued to speak positively about the friendly and homely culture within the home.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service continued to be rated as requires improvement.

Whilst staff knew how to support people in a way that minimised identified risks, records relating to this were not always accurate. Similar concerns were found in relation to medicines records. We were concerned this could impact on people's safety.

There were sufficient numbers of staff to meet people's needs.

Staff followed infection control guidance and the home was visibly clean.

Incidents and accidents were investigated and remedial actions taken in response.

Health and safety checks were carried out to ensure the safety of the building and equipment within it.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect.

Staff understood their responsibility to raise concerns and report on incidents and accidents.

Is the service effective?

Requires Improvement

The service had deteriorated to requires improvement.

Where people were unable to make more complex decisions about their care and support, staff had not always followed relevant guidance in the MCA 2005.

Overall, the design and layout of the premises met people's needs, but further action was needed to ensure that all aspects of the premises were well maintained and in a good state of repair.

Staff were all aware of people's dietary needs and preferences and people appeared to enjoy the food provided.

Staff received the training and support they required to meet

people's individual needs. Staff worked well with external health care professionals and people were supported to access health services when required.

Is the service caring?

Good

The service remained good.

Is the service responsive?

Good

The service remained good.

Is the service well-led?

Requires Improvement

The service had deteriorated to requires improvement.

The governance and quality assurance systems were not being fully effective at monitoring the quality and safety of the service. We found a number of areas where records relating to people's care, and to the management of the service, were not complete, accurate and up to date.

Relatives and staff expressed confidence in the registered manager and their ability to manage the home well. Everyone continued to speak positively about the friendly and homely culture within the home.

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 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 service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection which took place on 7 and 9 January 2019. The inspection was undertaken by 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. A notification is where the registered manager or provider tells us about important issues and events which have happened at the service. The provider had completed a provider information return. A PIR 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.

Due to their complex needs, most people were unable to tell us about their experiences of living at The Laurels. We were able to have a brief conversation with one person but also spent time observing the care being provided. We spoke with the registered manager, three representatives of the provider, Dolphin Homes, and five care workers. We viewed the care and support records for three people and the recruitment records for three staff members who had been employed since our last inspection. We also viewed other records relating to the management of the service such as staff rotas, audits and policies.

Following the inspection, we spoke with three relatives and received feedback from three health and social care professionals about the care provided at The Laurels.

Requires Improvement

Is the service safe?

Our findings

Relatives were confident their family members were safe at The Laurels. One relative said, "I can walk in at any time on any day, there is never anything to hide, we are so lucky, there is never any sense of unhappiness…the guys are their priority".

We found some areas where improvements were needed. Whilst staff were aware of people's current risks and how to manage these, records relating to risk management strategies were not always accurate. For example, three people had been assessed as requiring a modified diet due to their swallowing difficulties and risk of choking. In the case of one person their eating and drinking risk assessment contained incorrect information about their dietary needs, noting that the person required a 'fork mashable diet' when in fact they required a pureed diet. The same person's eating and drinking plan made reference to three different food consistencies. Similar inconsistencies were present in the care records of the second person. In the case of a third person, dietary guidance on display in the kitchen was incorrect and wrongly stated that the person required a fork mashable diet when in fact they needed a pureed diet. We were concerned that the contradictory nature of information could mean that new or agency staff might not have clear guidance on how to support people safely with their nutritional needs. The registered manager has taken action to ensure the relevant care records are updated.

Whilst people had choking risk assessments, we found that these were not always sufficiently personalised and would benefit from being reviewed to ensure they contain clear and personalised advice about how staff might best respond to a choking incident when the person uses a wheelchair and lives with complex postural conditions.

We were concerned that the current measures in place to prevent people leaving the premises without the required level of support were not robust enough in that the front door could be opened from the inside through operating a turning mechanism. The registered manager assured us that any risks associated with this were negligible as most people were unable to mobilise independently and they were confident that those that could would be able to operate the door lock mechanism and would not attempt to leave the premises. We recommend, however, that this is reviewed to ensured that all the required safety measures are in place.

A range of other risk assessments were in place. These included risk assessments in relation to communication, the use of bed rails, moving and handling, decision making and risk of developing pressure areas. Handovers were used to ensure that staff were aware of any new risks or concerns about a person's health. This helped to ensure changes to people's needs were effectively communicated to those that needed to know.

During our visit we looked at the systems that were in place for the receipt, storage and administration of medicines. Monitored dosage systems (MDS) were used for most medicines with others supplied in boxes or bottles. The medicines were stored safely and only administered by staff that had been trained and assessed as competent to do so. People had a medicines administration record (MAR) which contained

information such as their photograph and information about allergies they might have. The MARs contained no gaps or omissions and staff were aware of what they must do in the event of a medicines error being made.

We did, however, note some areas where improvements were needed. A number of people had been prescribed a type of 'rescue' or 'emergency' medicine to be given should they experience a seizure. In the case of one person, this had been received into the service on 23 November 2018, but there was still no medicines administration record for it. One person's MAR contained a prescription for Paracetamol in two different formats, liquid and tablet form. We were concerned this was a risk and could lead to the person receiving an overdose of the medicine.

Most people were prescribed 'as required' or PRN medicines. Whilst there were protocols in place which described the circumstances in which these might be needed, some of these contained conflicting information or were not accurate or up to date. For example, the PRN protocol for two peoples rescue medicines gave conflicting information about the dosage. Some people had PRN protocols for medicines they were no longer taking.

Whilst daily checks took place to ensure that people's boxed medicines were being administered correctly, in the case of two people, these checks did not include each of their medicines. We found that the medicines trolley could be cleaner. Liquid medicine bottles were sticky and in some cases stuck to the shelves. This had been a concern at our last inspection.

There was evidence that the provider had an approach to recruitment that ensured prospective staff shared their vision and value base. Interviews took place which were competency based and new staff were asked to spend time with people using the service to ensure they demonstrated a person-centred approach to people. Other recruitment checks were completed such as checks with the Disclosure and Barring Service (DBS) to ensure new staff had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post. Some improvements were needed however. One staff members file did not include a full employment history and the provider did not have a system in place to consider the physical and mental health of new staff before they were employed. We have asked that the provider review their policy in relation to this.

During our inspection, we observed that the staffing levels enabled people's needs to be met safely and in a timely manner. During the day there were four support staff and at night there were two waking night staff. No ancillary staff were employed and so the care staff were responsible for cooking, cleaning and activities. The staffing levels had been reduced since we last inspected the service and were directly linked to the amount of funding being provided by the commissioners of people's care and support. In addition, there were currently four staff vacancies which the registered manager was working hard to recruit to. In the interim, agency and bank staff were being used to cover gaps in the rotas. Where agency staff were used, these had usually worked at the home for some time which helped to ensure that people continued to receive support from people who knew them well.

Staff told us that the revised staffing levels were adequate. One staff member said, "We have had our hours cut, but I think now we have adapted and its ok. I don't think the guys miss out on any activities, maybe the laundry won't get done or the bathroom cleaned, but the night shift will pick that up". We had similar feedback from other staff. A health care professional did tell us that it could be challenging to implement strategies due to changes in staff, but they felt the registered manager did all she could to mitigate this.

Health and safety checks were carried out monthly to make sure the building and equipment within it were

maintained and serviced as required to make sure people were protected. These included regular checks of the environment, fire safety, gas and electrical systems. Each person had a personal emergency evacuation plan (PEEP) which detailed the assistance they would require for safe evacuation of the home. The provider also had a business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service. The senior management team planned to refresh their legionella training and ensure this was cascaded to the staff responsible for the onsite checks.

Staff followed infection control guidance and the home was visibly clean. Protective clothing, including gloves and aprons, was available and was used by staff appropriately. Records were maintained to show that cleaning schedules were followed.

Staff understood their responsibility to report incidents and accidents that took place. These were investigated and actions were taken in response to mitigate any risks. For example, following incidents of behaviour which might challenge, a behaviour analysis took place to consider what additional actions might be required to prevent a reoccurrence of the incident.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. Policies and procedures were readily available and set out the responsibilities of staff with regards to sharing and managing safeguarding concerns. Staff were aware of the whistle-blowing procedures, but were also confident they could raise any concerns with the registered manager and that these would be dealt with. All of the staff we spoke with said they had no concerns about the safety of people using the service with one saying, "If I wasn't sure [people were safe], I would most definitely follow the whistleblowing policy. They [people] have every single right we have. They should be treated like we like to be treated".

Requires Improvement

Is the service effective?

Our findings

Relatives and healthcare professionals told us The Laurels provided effective care. For example, one relative told us, "I am very happy…they give [family member] the best care possible" and another said, "From what I see, I couldn't do any better". A health care professional told us how the person they supported had very complex needs, but despite this, they were putting on weight and had good skin integrity.

We looked at how the service was acting in accordance with the Mental Capacity Act 2005 (MCA). The MCA 2005 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The registered manager and staff displayed a commitment to protecting and respecting people's rights. It was positive that many of care records referred to the risk of disempowering people and importance of giving people, despite their limited communication, the opportunity to express their wishes and choices wherever able. We continued to observe that staff supported people in a manner that was in keeping with these values and guidance.

However, we also continued to find that where people were unable to make more complex decisions about their care and support, staff had not always acted in accordance with the MCA 2005. For example, mental capacity assessments were not decision specific and not documented appropriately. Staff had not documented when best interests' consultations had been undertaken to demonstrate how external professionals and family members had been involved in reaching a shared decision about how people's care and support should be provided when they lacked the capacity to decide this for themselves.

In some cases, monitoring equipment allowing staff to remotely listen or observe people when they were sleeping was being used. This was to allow staff to be alerted to the person experiencing a seizure for example and to protect them from harm. Some people also had bed rails in place to prevent them from falling from bed. However, the use of such equipment is potentially intrusive and restrictive practices such as these should only be used with the person's consent. If the person lacks capacity to make this decision, there should be a best interests consultation which demonstrates how the proposed action is in the person's best interests and is the least restrictive option. This was not in place. We had identified similar concerns at our last inspection and insufficient action had been taken to address these.

The failure to act in accordance with the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The need for consent.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications for DoLS had been submitted by the home and had either been authorised or were awaiting assessment.

Overall, the design and layout of the premises met people's needs. 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. In addition, the home had a lounge and conservatory, a kitchen, a games/sensory room, a laundry and a staff office.

The provider had a five-year plan for refurbishment of the premises and the lounge for example, had recently been refurbished. However, further action was needed to ensure that all aspects of the premises were well maintained and in a good state of repair. For example, on the first day of our inspection, there was a lot of rubbish and old furniture being stored in the garden which was unsightly. This was removed during the inspection. In one person's room, there was an hole in their wall which needed repair and in two people's rooms, the window handles had fallen off. A number of the bed rail bumpers needed to be replaced. The registered manager told us these were on order. Records indicated that the external security lights had not been working for some time. These were fixed during the inspection. In two of the first-floor rooms, the window restrictors were not sufficiently robust and could be easily overridden. No one living on the first floor could independently mobilise and so the risks of people falling from windows was reduced, but we recommend that the provider ensure the restrictors conform with standards recommended by the Health and Safety Executive.

New staff completed an induction during which they learnt about the provider's aims and objectives, their role and responsibilities, read support plans, policies and procedures and became acquainted with the environment and people using the service. New members of staff were supported to complete the Care Certificate. The care certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. Support workers told us they received periodic supervision and felt supported in their role and felt able to approach the registered manager for advice or support at any time. Supervision is important as it helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities.

Staff completed training in a range of subjects such as person-centred care, fire safety, safeguarding adults, medicines management food hygiene, equality and diversity, first aid, infection control, Mental Capacity Act (MCA) 2005 and manual handling training. Staff received additional training relevant to the needs of people using the service. For example, staff had received training in caring for people living with epilepsy and in the care and management of artificial feeding devices. Most of the training was up to date or a date was planned for this to be completed. All the staff we spoke with said that the training provided was adequate to enable them to perform their role effectively.

Each person had a set of support plans which described their physical, social and emotional needs and provided staff with guidance on how to meet these needs. For example, one person's eating and drinking support plan contained detailed guidance on the care of their artificial feeding device and on the management of their seizures. Where necessary people had a positive behavioural support plan to support staff to manage behaviour which others might find challenging. Staff told us support plans were helpful and told them how best to support people. However, as described elsewhere in this report, some of the support plans and associated records contained inaccuracies or were not fully up to date. For example, two people's support plans stated that they should be checked every 30 minutes at night. Other records showed this was not happening. The registered manager told us the support plan should have been updated to reflect hourly checks were now taking place. We found that one of the hospital passports we viewed contained inaccurate information about a person's dietary needs and allergies and had not been reviewed in the last year. Hospital passports provide hospital staff with important information about people, their communication needs and physical abilities when they are admitted to hospital.

Staff were all aware of people's dietary needs and preferences, but as noted elsewhere in this report,

people's need for a modified diet had not always been clearly or correctly recorded in their support plans. Support plans did include guidance how the person should be positioned during meals and the use and care of artificial feeding devices. Staff tried to involve people in decisions about what they ate and each week people, and staff, sat down together to plan the weekly menu. Staff continued to take the lead in preparing meals, but we observed that people were encouraged to join staff in the kitchen and be as involved as possible, by for example, using hand over hand techniques to stir cake mixes, or just to enjoy the sensory sensation of smelling the meal cooking. One staff member said, "I get [people] involved in baking, even if its just eating the cake mixture". People were encouraged where possible to choose some healthy options for their meals.

Staff were attentive and did not rush people when supporting them to eat and drink. For example, we saw one staff member say to a person they were supporting, "Are you ready for some more [food], slowly, that's better". They asked the person if they could wipe their mouth throughout the meal to maintain their dignity.

People seemed to enjoy the food provided and this was confirmed by the person we spoke with. Staff knew who needed a little extra encouragement to eat and food and fluid charts were being used to monitor the nutritional intake of some people, although we noted these were not being totalled which limited their effectiveness as a monitoring tool. The registered manager told us that a new electronic support planning system was being introduced in approximately a months' time and would include new facilities to more effectively record and monitor fluid intake.

Where necessary staff worked effectively with a range of other healthcare professionals to help ensure that people's healthcare needs were met. This included GP's, physiotherapists, dieticians and speech and language therapists. People had recently had annual medicines reviews to help ensure their medicines remained appropriate for their needs. People were supported to attend dental and optician appointments.

Good

Is the service caring?

Our findings

We observed staff interacting with people throughout the day and it was evident that staff and people enjoyed good relationships. We observed that staff spoke to people kindly, respectfully and cheerfully. The kind and patient approach of staff was commented on by many relatives, for example, one relative said, "They are very kind and caring…its very much like a family".

Our observations indicated that staff listened to people and respected their choices and wishes, encouraging them to be involved in making everyday decisions about the care and support provided. We observed staff encouraging people to make choices about what they would like to do and what they wanted to eat. Where people were not able to verbally communicate their choices, staff used alternative methods to try and assist them to make choices and express their preferences. People's support plans included a Decision Making / Choices Risk Assessment'. This clearly emphasised the importance of including people in decisions wherever possible to avoid disempowering them and excluding them from the world around them.

Staff were confident that their colleagues were kind and caring. We heard staff continuously used positive language when communicating with people and their approach and mannerisms were person centred at all times. Staff smiled and acknowledged each person they met, and praised and encouraged them at every opportunity. For example, we heard staff saying, "Well done [person] you've smashed it". This was in response to the person eating well. We saw one person respond with a big smile when a staff member engaged with them. The staff member said, "What's that big smile for", they chatted to the person about their new slippers. While the person could not verbally respond, they appeared at ease and comfortable.

Staff spoke proudly about the people they cared for and consistently emphasised that the Laurels was people's home and there was a family feel to the nature of care. For example, one staff member said, "I love the guys, the staff, it's like a little family unit" and another said, "This is an amazing place to work, these guys are like family, all the staff here step into their home and we care for them like family". A health care professional also commented on the homely nature of the home saying, "For these guys, it's a home not a care home".

People using the service were encouraged and supported to develop and maintain relationships with people that mattered to them. Staff had arranged and accompanied one person on visits to their family in the north of England on two occasions in the last year. Friends and relatives could visit at any time and retain a role in their family members care or share a meal with them. Special events such as birthdays, Halloween and Valentine's day were celebrated with parties. Staff supported people to purchase presents for their family members, which relatives valued. Relatives said they felt welcome and had a good relationship with support workers and management. They too commented on the homely nature of the service.

Staff were mindful of people's privacy and dignity. One staff member said, "We make sure doors are shut… we cover them when coming out of the shower, or going in, you don't want them to feel vulnerable and we

don't talk about them in front of anyone else". Signs were displayed on the door to ensure that others knew personal care was taking place and therefore should not enter the room.

People were encouraged to remain as independent as possible and details of what people could do, and those things they needed support with, were recorded in their support plans. At lunch time, we saw a staff member encouraging one person to pick up their own sandwich to eat which occasionally they managed. A staff member told us that one person could weight bear a little and had a walking aid, so staff tried to encourage them to walk whilst being mindful of their safety.

Where people needed advocates to support their decision making, these were made available. The registered manager had used a systematic approach to advocate for one person for whom healthcare professionals were recommending a nil by mouth diet. The registered manager could evidence through the use of observation and charts that the person's coughing was not related to their eating and drinking. They advocated that it was not in the person's best interests to become nil by mouth as taking away their ability to taste food would impact on their quality of life. A relative told us, "If something is not right, [the registered manager] will be [family members] mouthpiece.

Good

Is the service responsive?

Our findings

Relatives were happy that care workers understood how to meet their family member's care and support needs. For example, one relative said, "They [staff] know her better than I do, they all have a fantastic rapport, they know what she wants, it's a lovely relationship". They explained that their family member's "Face beamed" when they were told it was time to go back to The Laurels after visits to their home. A health care professional told us people received "Personalised care, they are treated as an individual, staff tailor every part of their day to their very complex and high needs".

Overall support plans provided a person-centred record of the person's needs. They contained some specific, individual information, about the person such as their preferred daily routines and who they preferred to assist them with personal care and how staff might best support them at night. For example, one person liked to wear matching clothes and liked their hair to be gelled and styled which we saw to be the case. Plans described how and where people liked to take their medicines and individualised communication plans and passports were in place which described the ways in which they might communicate. Equality and diversity plans were in place which described the barriers people might face to leading their life like every other citizen. Guidance was available on how staff might support people to overcome these barriers. Whilst there was currently very little in the support plans regarding people's spiritual needs or sexuality, the registered manager told us the provider was working with a service aimed at helping people access education in relation to sexual health, emotions and managing relationships.

Our observations indicated that staff knew people and their individual preferences well and this helped to ensure that people received care that was centred on them as a person. For example, staff were aware what the different vocalisations of one person might mean. This helped staff to understand whether the person was happy or hungry. Throughout the day people were happy and engaged and it was evident that staff, including the agency staff, understood how to communicate with them. Staff changed their approach depending on the needs of the person, for example, staff communicated with one person by encouraging them to express yes or no through tapping one hand or the other. For another person, staff used their facial expressions to understand their choices. Other people were less able to express their choices, but staff still tried to engage with them. For example, we saw staff talking with one person about a party they had gone to at the weekend and how much they had enjoyed the food. They reminded the person about something funny that had happened to a member of staff at the party to which the person chuckled. They were clearly enjoying the banter with staff. A staff member told us, "I ask [person] if they would like Cornflakes or Weetabix and get a massive smile when it's the right one. You get to know them, you know if they are unhappy or not well, you pick up on their sounds, [person] is amazing, you don't get much back in verbal communication, but you do in their body language".

There was evidence that people were supported to take part in leisure activities. Within the home, people spent time listening to music, watching the TV and playing board games with staff which some people seemed to be greatly enjoying. We observed staff reading The Wonky Donkey story to one person who was giggling throughout. Staff also led karaoke sessions which we were told were greatly enjoyed by people. One staff member was building a remote-controlled car track for one person in their room, set at just the right

height for their wheelchair. Outside of the home, people went bowling, shopping, to local outdoor pursuits centres, day centres and hydrotherapy. Relatives told us their family members had over the last year visited the theatre, cinema and safari park for a festival of light. One relative told us that their family member had been on a trip to Brighton where they had gone on the ghost train which made them laugh all the way round the ride. Two people were taking part in a hydrotherapy programme for which they had received training from the community physiotherapy team. The provider held a sports day and talent show with a Grease theme, for which staff and people made a cardboard car and sang and danced to music from the file. The registered manager told us this was enjoyed by all. People were taken on holidays. Some people had enjoyed stays at a national holiday village and one person had been Disney. A staff member said, "They have a great life…everyday two or three of them go out".

The registered manager and staff sought opportunities for people to influence how their care was delivered. For example, weekly meetings with people were held. The aim of these was to plan activities and the menu for the coming week. Staff recorded that they used flashcards to support people to express choices about activities and the menu for the coming week, but minutes showed this was with only limited success due to people's complex needs. The daily records viewed were mainly task focussed and could better reflect the person-centred care we saw being delivered. Whilst support plans were reviewed and people had key workers, there was limited evidence that key workers played an active role in supporting people, along with relevant others, to ensure that support planning and delivery continued to be focussed on the person's individual goals and objectives. This is important to ensure that people's daily support remains relevant and purposeful.

The relatives we spoke with were confident they could raise concerns or complaints and these would be dealt with. For example, one relative said, "If there are ever any issues, I know it gets sorted, there are never any repercussions". A health care professional told us, "If you raise a problem, [the registered manager] will do what she can as quick as she can". Where complaints or concerns had been raised, these had been investigated thoroughly and a note made of any remedial actions being taken. The provider encouraged people and their relatives to give feedback about the service. Bi-annual questionnaires were completed with the most recent being done in December 2018. The feedback from these was largely positive. The registered manager told us that where necessary an action plan would be developed to address any areas for improvement.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. There was some accessible signage around the home and an easy read version of the complaints procedure was displayed. Staff used flashcards to support people to make choices about their meals and activities. Staff had a basic understanding of Makaton and used this to communicate key messages to people who understood this. Makaton is a language programme using signs and symbols to help people to communicate.

Technology was used within the service to help staff provide timely and responsive care. Staff were having training on the use of an eye driven tablet communication system which it was hoped might enable one person to communicate more. Video and sound monitors were used to check whether people might be experiencing seizures and there were plans to shortly upgrade these to watches which it was hoped would be more effective.

Most of the people living at The Laurels were younger adults and to date, the registered manager had not explored their end of life wishes with them or their families. We recommend that the registered manager use guidance such as that published by NHS England End of Life Care team, in partnership with the Palliative

Care for People with Learning Disabilities Network, Delivering high quality end of life care for people with a learning disability to effectively engage with people, their families and carers to ascertain their individual needs, expectations and wishes in relation to their end of life care.

Requires Improvement

Is the service well-led?

Our findings

There were systems in place to assess and monitor the quality and safety of the service. The provider undertook six monthly audits which were aligned to the key lines of enquiry that the service is inspected and rated upon. The audit included an action plan detailing the areas where improvements were required, the steps needed to deliver these and a clear time scale for completion. The area manager also completed a comprehensive monthly audit of the service. The registered manager regularly provided direct support to people and worked alongside the staff team, allowing them to observe staff practice to ensure this was person centred and staff undertook a range of health and safety checks and daily medicines audits.

Despite these measures, the quality assurance arrangements, were still not being fully effective at identifying current and potential concerns and areas for improvement. For example, the audits had not addressed the concerns we found with regards to the mental capacity assessments or the areas where records relating to the running of the service and support plans were inconsistent or inaccurate. We were concerned that the audit system for medicines was not being fully effective as it had not ensured that the issues we identified and addressed. This had been a concern at our last inspection.

We also found other records related to the management of the service needed to be more robust. For example, records showed that there had been an outbreak of sickness within the service affecting four people in August 2018. We were unable to see what actions had been taken in response to this outbreak as there were no further records relating to this and the outbreak had not been reflected in the annual infection control statement.

The governance and quality assurance systems were not being fully effective at monitoring the quality and safety of the service. We found a number of areas where records relating to people's care, and to the management of the service, were not complete, accurate and up to date. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

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 in the form of a 'notification'. Important events include accidents, incidents or allegations of abuse. This is important as it ensures CQC have appropriate oversight of emerging risks within services. We found two occasions where notifications should have been submitted but had not. One of these had occurred when the registered manager was on leave from the service. Upon discussing this with the registered manager, it was clear that they understood their responsibilities and that this had been a genuine oversight.

Relatives expressed confidence in the registered manager and their ability to manage the home well. One relative said, "Since [the registered manager] has been in charge, its lovely, it's their [peoples] home…. the guys are her priority". Another relative said, "She gets down and dirty…gets in with the team, leads by example…. she will come in on her day off to support the staff, she deserves the job".

Feedback from staff about the registered manager was also positive. One staff member said, "I believe she is

a good manager, all the staff know the office door is always open, she will come in if we are short, do activities, she is a very good manager". Another staff member said, "[Registered manager] is most definitely without a doubt one of the best managers I have worked for…. she is out there, does get involved, her door is always open, we don't hesitate to ask anything, she is a wonderful lady".

Staff told us that they were happy working in the service and that teamwork and morale was good. One staff member said, "Every day is different, its satisfying putting joy into people's lives and we get to do lots of different activities that are fulfilling, its good to give something back".

Staff meetings were held quarterly during with staff discussed issues affecting the people using the service, developments such as the General Data Protection Regulations and staffing matters such as the management of sickness and rotas. Minutes showed that staff were encouraged to share their views and comments to improve the quality of care.

Our observations indicated that the registered manager had a good rapport and knowledge of the people using their service and it was clear that they were committed to working in a collaborative manner with their staff team to meet people's needs. They told us, "The service users are put first, they are the centre of my attention, we maintain a good life for them". However, rotas showed that on a regular basis, they were being required to provide direct support to cover gaps in the rota. The registered manager enjoyed being able to support people and preferred this to using unfamiliar agency staff for consistency which is positive. We were concerned however, that this had impacted upon their ability to perform their management responsibilities and to have oversight of quality and to drive improvements such as those identified in this report. We recommend that the registered manager and provider seek ways to ensure there is sufficient managerial capacity within the service to ensure effective governance is carried out.

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 11 HSCA RA Regulations 2014 Need for consent When a person lacked capacity to consent to make an informed decision, or give consent, staff had not adequately demonstrated that they were acting in accordance with the requirements of the Mental Capacity Act 2005 and it associated Code of Practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The governance and quality assurance systems were not being fully effective at monitoring the quality and safety of the service. We found a number of areas where records relating to people's care, and to the management of the service, were not complete, accurate and up to date.