Isle of Wight Council

The Laurels

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The Laurels is a local authority run residential home, which provides accommodation for up to six people with learning disabilities who need support with their personal care. At the time of our inspection there were five people living in the home

The inspection was unannounced and was carried out on 22 July 2016.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People were supported to have enough to eat and mealtimes were a social event. Staff supported people, when necessary in a patient and friendly manner. However, there was an inflexible approach to the provision of drinks, which did not take account of personal choice and weather conditions. We have recommended that the provider seek advice and guidance on adopting the latest best practice in respect of a person centred approach to meeting people's hydration needs.

Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. They were patient when engaging with people who could not communicate verbally and who used a variety of signs, sounds and body language to express themselves. Staff were able to understand people and respond to what was being said.

People told us and indicated that they felt the home was safe. Staff and the registered manager had received safeguarding training. They were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided sufficient information to allow staff to protect people whilst promoting their independence.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs. There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessments.

Staff followed legislation designed to protect people's rights and ensure decisions were the least restrictive

option and made in their best interests.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to maintain relationships that were important to them.

Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary. They were also encouraged to provide feedback on the service.

There was an opportunity for families to become involved in developing the service and were encouraged to provide feedback on the service through an annual questionnaire.

People were supported to raise concerns and complaints should they wish to and were supported to do so by keyworkers and advocates.

People's families told us they felt the home was well-led and were positive about the registered manager, who understood the responsibilities of their role. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the home.

There were systems in place to monitor quality and safety of the service provided.

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

The service was safe.

The registered manager had assessed individual risks to people and had taken action to minimise the likelihood of harm in the least restrictive way.

People received their medicines at the right time and in the right way to meet their needs.

People indicated that they felt the home was safe and staff were aware of their responsibilities to safeguard people.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

Is the service effective?

Requires Improvement

The service was not always effective.

There was an inflexible approach to the provision of drinks, which did not take account of people's preferences or the weather. People were supported to have enough to eat.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights. People had access to health professionals and other specialists if they needed them.

Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

Where possible people were encouraged to maintain friendships and important relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

Care plans and activities were personalised and focused on individual needs and preferences.

The registered manager sought feedback about the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well-led.

The provider's values were clear and understood by staff. The registered manager adopted an open and inclusive style of leadership.

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment.

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.

The inspection was unannounced and was carried out on 22 July 2016 by two inspectors. 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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with one person using the service and engaged with three others, who communicated with us verbally in a limited way. We also received feedback from three health professionals. We observed care and support being delivered in communal areas of the home. We spoke with three members of the care staff, the deputy manager and the registered manager.

We looked at care plans and associated records for the five people using the service. We also reviewed records about how the service was managed, including staff duty records, staff training, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

This is the first inspection since the home was registered with the commission in June 2013.

Good

Is the service safe?

Our findings

People told us and indicated they felt safe. One person "Staff look after me". Other comments include "yes safe here" and "happy". We observed the people who were unable to tell us verbally about their experiences and saw they were relaxed and engaged fully with the staff who were supporting them. Health professionals told us they did not have any concerns regarding people's safety.

People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. All of the staff and the registered manager had received appropriate training in safeguarding. Staff knew how to raise concerns and how to apply the provider's policy. One member of staff told us if they had any concerns, "I would intervene and then report it to the manager. If they weren't prepared to act I would go higher". The registered manager explained the action they would take when a safeguarding concern was raised with them and the records confirmed this action had been taken when a safeguarding concern had been identified.

People were protected from individual risks in a way that supported them and respected their independence. The registered manager had assessed the risks associated with providing care to each individual; these were recorded along with actions identified to reduce those risks. They were personalised and written in enough detail to protect people from harm, whilst promoting their independence. For example, one person, who used a wheel chair to mobilise, had a risk assessment in place in respect of the need to use a lap strap when staff supported them to move around the home. During the inspection we observed staff monitoring this person to ensure they were wearing their lap strap in line with their risk assessment.

Staff were able to explain the risks relating to people and the action they would take to help reduce the risks from occurring. Where an incident or accident had occurred, there was a clear record, which enabled the registered manager to identify any actions necessary to help reduce the risk of further incidents. Each person's care plan contained a 'Vulnerable Adult Form', which provided the information necessary for health professionals to support that person should they be taken to hospital in an emergency.

People told us and indicated there were sufficient staff to meet their needs. The registered manager said that staffing levels were based on the needs of the people using the service. The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a relaxed and unhurried manner. Staff responded to people's needs promptly. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime, staff employed by the provider at other homes, the provider's bank staff and agency staff. The registered manager was also available to provide extra support when appropriate.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

People received their medicines safely. Staff had received appropriate training and their competency to administer medicines had been assessed by the registered manager to ensure their practice was safe. Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. There were suitable systems in place to ensure the safe storage and disposal of medicines. A refrigerator was available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturer's instructions. There was a medicine stock management system in place and a process for the ordering of repeat prescriptions and disposal of unwanted medicines. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Staff were aware of the fire safety procedures and the action they would take if an evacuation was necessary.

Requires Improvement

Is the service effective?

Our findings

People told us and indicated they felt the service was effective and that staff understood people's needs and had the skills to meet them. One person said, "Staff help me". Another person told us that staff were, "all good".

There was an inflexible approach to the provision of fluids, which did not take account of people's personal choice or weather conditions. Drinks were offered with the meals and at 10.30am and 3.30pm. Staff told one person who was requesting a drink during the morning, "It is a bit early yet". Although the weather was hot, there were no jugs of water or juice available for people to drink. A senior member of staff told us "We have set times for coffee in the morning and afternoon because [some of the people] would continue to drink all day and make themselves ill". We raised this with the registered manager who told us they would review the practice to ensure people's needs were met.

We recommend that the provider seek advice and guidance on adopting the latest best practice in respect of a person centred approach to meeting people's hydration needs.

People were supported to have enough to eat. People told us and indicated that they enjoyed their meals. Comments included "it's good", "tasty" and "nice".

Staff who prepared people's food were aware of their likes and dislikes, allergies and preferences. The menu was published on a noticeboard in the dining area and was supported by pictures to help people understand what meals were being planned for them. Meals were appropriately spaced and flexible to meet people's needs. Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner. Staff were aware of people's needs and offered support when appropriate. For example one person who was on a soft diet wanted a biscuit with their drink. A member of staff sat with this person and encouraged them to dip their biscuit into their drink to soften it up and take their time when eating it. The member of staff was aware of the risks relating to this person eating biscuits and was aware of the action to take if concerns were identified.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. For example, a best interest decision had been made in respect of one person regarding their admission to hospital for minor surgery.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. DoLS applications had been made to the supervisory body with the relevant authority for all of the people using the service. The registered manager carried out a review of the applications on a regular basis to ensure they were still required. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence. People's families and other representatives had been consulted when decisions were made to ensure that they were made in people's best interests and were the least restrictive option.

People told us and indicated that staff asked for their consent when they were supporting them. One person said, "I tell them if I don't want something". Staff sought people's consent before providing care or support, such as offering to provide support to help them mobilise. We observed staff seeking consent from people using simple questions and giving them time to respond. One member of staff told us, "I always seek consent. For example I ask [person] do you want your bath now. If he refuses, it's his choice. I will try and encourage him but if they don't want one they don't have to have it". Daily records of care showed that where people declined care this was respected.

People were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. The registered manager told us they had not recruited any new staff for three years. They told us any new staff would receive an induction and training, which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life.

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. Staff had access to other training focused on the specific needs of people using the service, such as, epilepsy and dementia awareness, understanding learning disabilities, Mental Capacity Act and Down syndrome. Staff were supported to undertake a vocational qualification in care. Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, how they supported people who were living with a learning disability to make choices and maintain a level of independence.

Staff had regular supervisions. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported by the management team and senior staff. There was an open door policy and they could raise any concerns straight away. One member of staff told us they had recently had a supervision and added "If I have any problems I would speak to [the senior]".

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail. Health professionals told us that staff listened to their advice and carried out any actions they requested.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. People's comments included "Nice staff, I like [named member of staff]" and "It's good here". Health professionals told us staff we caring and supportive of people living in the home.

People were cared for with dignity and respect. Staff spoke to them with kindness and warmth and were observed laughing and joking with them. One member of staff saw that a person who was sat at the table in the lounge was looking distracted. They asked them if they would like to go outside to feed the birds. The person agreed and went happily outside. Staff were attentive to people and checked whether they required any support. For example, one person was sat in the lounge on their own. Staff continually checked with this person to see if they needed anything or wanted assistance to mobilise to a different location.

Staff understood the importance of respecting people's choice and privacy. They spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what they preferred to eat and whether they took part in activities. Choices were offered in line with people's care plans and preferred communication style. Where people declined to take part in an activity or wanted an alternative this was respected. One person was due to go to film club during the morning but changed their mind and wanted to stay at the home. Staff quickly adapted to the change of plan.

We observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited for a response before entering. Staff described the practical steps they took to preserve people's dignity when providing personal care, such as keeping them partially covered with towels and closing doors and curtains.

People's care plans were centred on the person as an individual. They contained detailed information about their life history to assist staff in understanding their background and what might be important to them. Staff used the information contained in people's care plans to ensure they were aware of people's needs and their likes and dislikes.

People were encouraged to be as independent as possible. One person, using a wheelchair to mobilise, wanted to go into a different room. Staff encouraged him to propel himself, in line with his care plan. Staff remained with the person offering support and guidance when appropriate. Once they had reached their final destination staff praised the person's efforts and we saw their face, reflected a sense of achievement.

Although the people living in the home had limited contact with families or friends, where possible they were supported to maintain friendships and important relationships. For example, one person was supported by staff to visit their mother who was in another home living with dementia.

People's bedrooms were individualised, reflected people's interests and had been recently painted, in line with people's preference. The registered manager explained that each person had been shown a series of colour charts from which to pick the colour they wanted their room. The bedrooms were personalised with

photographs, pictures and other possessions of the person's choosing.

Information regarding confidentiality formed a key part of staff's induction training for all care staff. Confidential information, such as care records, was kept securely within the office and only accessed by staff authorised to view it. Any information, which was kept on the computer, was also secure and password protected.

Good

Is the service responsive?

Our findings

People told us and indicated they felt the staff were responsive to their needs. Health professionals told us that staff knew people well and responded appropriately to their changing needs.

. Staff were responsive to people's communication styles and gave people information and choices in ways that they could understand. Staff used plain English and repeated messages as necessary to help people understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond. People's care plans included a section titled 'Top tips for supporting me' which included communication, which provided information about their communication style. Those people who were not able to verbally communicate with staff, were able to demonstrate their understanding about what they were being asked and could make their wishes known

People received care and treatment that was personalised and support from staff who were knowledgeable about their needs and the things that were important to them in their lives. Staff's understanding of the care people required was enhanced through the use of care plans, which detailed people's preferences, backgrounds, medical conditions and behaviours. They also included specific individual information to ensure medical needs were responded to in a timely way. Care plans and related risk assessments were reviewed monthly to ensure they reflected people's changing needs. Each person had an 'easy read' health action plan supported by pictorial representations suitable for the needs of the person they related to. Where possible, this was used to encourage people to become involved in developing their care plan. One member of staff said, "I always check the care plans. A couple of residents have behaviours we are monitoring so I check to see what has changed. I also look in the communications book".

The registered manager ensured that the environment was suitable for people's changing needs. For example, one person's bedroom was carpeted to provide extra protection due to their risk of falls, while the others were fitted with laminate flooring to make it easier for people to use wheelchairs and walking frames.

People's daily records of care were documented in individual support diaries. These provided a daily narrative of the person's behaviour, activities and the care provided. These diaries were up to date and showed care was being provided in accordance with people's needs. Care staff members were able to describe the care and support required by individual people. For example, one care staff member was able to describe the support a person required with their meals and when mobilising. This corresponded to information within the person's care plan. Handover meetings were held at the start of every shift and supported by a communication book. The handovers provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting.

Each person had an allocated keyworker, whose role was to be the focal point for that person and maintain contact with the important people in the person's circle of support. They also supported the person with their shopping, managing their clothes and maintaining their room. Each of the key workers carried out a monthly review with the person of the activities they had engaged with and the activities they might like to

try. When appropriate, they discussed their health needs and asked for the person's views about their support.

Staff were knowledgeable about people's right to choose the types of activities they liked to do, and respected their choice. People had access to activities that were important to them. The senior staff member told us that activities in the home were focused on the individual and their needs, such as individual games, colouring, watching television and listening to music. People were also offered the opportunity to take part in some group activities such as, a film club and an arts and craft sessions. These were in another part of the building and provided an opportunity to interact with people from other locations owned by the provider. Although, there was limited opportunity for people to access spontaneous activities in the community, organised outings were arranged in line with people's interests. For example, one person told us that staff had recently taken him to watch an Air Show on the mainland.

People were supported to provide feedback or to raise concerns if they were dissatisfied with the service provided at the home. People also had access to both lay advocates who were available to support them if they were unhappy about the service provided and Independent Mental Capacity Advocate (IMCA). An advocate had been involved in supporting two people in discussions about a possible move of home.

The registered manager also sought feedback through the use of quality assurance survey questionnaires sent to people's families, visitors and health professionals. The registered manager told us they had not received any feedback from people's families. We looked at the feedback provided by health professionals from the latest survey, in September 2015, which was positive in respect of the care people received. Comments included 'Very caring; able to follow instructions', 'Calls to GPs well balanced. Not over cautious', 'Reliable, helpful and friendly staff' and 'Support supplied at dental appointments always seems to be appropriate and compassionate'.

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. The information on how to make a complaint also included details of external organisations, such as the Care Quality Commission and the Local Government Ombudsman. The registered manager told us that people's keyworkers would support them to raise any complaints. The registered manager told us they had not received any complaints about the care provided by the home during the previous year. They added they had recently received a complaint from a neighbour in respect of noise and they were in the process of dealing with this.

Good

Is the service well-led?

Our findings

Health professionals told us they felt the home was well led and they had no concerns in respect of the running of the home.

There was a clear management structure, which consisted of a registered manager, senior care staff and a learning disabilities group manager. Staff understood the role each person played within this structure. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. One staff member told us they had worked at the home for a long time because "the staff team was good and the management supportive". They added the registered manager was, "very approachable". Another member of staff told us, "Management are approachable. I have known [the registered manager] a long time. I am never shy in going forward with issues. When I raise something they listen and act on it". A third member of staff said, "It's a good team and a pleasure to come to work".

The provider, whose vision and values were built around supporting people as individuals and encouraging them to live to the best of their ability, was fully engaged in running the service. Care staff were aware of the provider's vision and values and how they related to their work. Regular staff meetings, which were integrated with the daily handover process, provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision.

Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. A staff member said, "When we raise something it is definitely acted upon. For example, I saw a metal strip on a carpet had come adrift. I informed [the registered manager] who had someone out the same day to fix it".

The provider had suitable arrangements in place to support the home's management team, through the group manager for Learning Disabilities Homes. The registered manager told us they felt supported as a result of regular meetings with the group manager, which also formed part of their quality assurance process. They were also able to raise concerns and discuss issues with the registered managers of the other learning disabilities services owned by the provider if they had any concerns.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. The registered manager carried out regular audits which included infection control, the cleanliness of the home, people's bedrooms, medicines management and care plans. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, the medicine cupboard temperatures and fire safety. They also carried out an informal inspection of the home during a daily walk round. Where issues or concerns were identified an action plan was created and managed through the regular meeting processes.

The home had a whistle-blowing policy which provided details of external organisations where staff could

raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration.