Methodist Homes

Lauriston

Inspection report

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31 January 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 22, 25 and 31 January 2018 and was unannounced.

Lauriston is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Lauriston is a purpose built, fully adapted service registered to accommodate up to 60 people who require nursing or personal care. The service specialises in providing nursing care to older people with age related conditions, including dementia. The service is divided into four units spread over two floors, with access to the upper floor via stairs and a lift. There is a car park to the front of the building and gardens to the rear. There were 49 people living at the home at the time of the inspection. There were 17 people on the dementia unit, 17 on the nursing unit and 14 people who required support.

At the last inspection on 11 November 2016 the service was rated Good. At this inspection we found the service remained Good with requires improvement in well-led.

There were processes and procedures for monitoring the quality of care provision. However, some improvements were needed to ensure action was promptly taken when issues were identified. This was because staff had not ensured that as 'required medicines' were all supported by a protocol and pain chart to ensure they were used safely. This was addressed immediately. Risk assessments did not always demonstrate a framework that supported people to take everyday risks. There had been an increase in safeguarding notifications over the past eight months. These were recorded but lacked a root core analysis and follow through to demonstrate learning from these situations. Root cause analysis is a collective term that describes a wide range of approaches, tools, and techniques used to uncover causes of problems.

There were enough staff to provide safe and effective care that met people's needs. Recruitment procedures ensured staff were qualified and safe to work with people who lived in the home. Staff understood their safeguarding responsibilities and the action they should take if they were concerned a person was at risk of harm.

The provider used a variety of risk assessment tools to identify any potential risks to people's health and safety. Risk management plans guided staff on how to manage those identified risks. Daily records to support risk management were consistently and accurately completed. Accidents and incidents were recorded by staff and analysed by the deputy manager to identify any emerging trends or patterns, so appropriate action could be taken to minimise identified risks.

People received care from staff who had the knowledge, skills and competencies to support their health needs. Medicines were ordered, received, stored, administered and disposed of in accordance with good practice. Staff understood their role and responsibilities in relation to infection control and hygiene. The

provider assessed people's capacity to make their own decisions if there was a reason to question their capacity. Staff and the registered manager had a good understanding of the Mental Capacity Act. Where possible, they supported people to make their own decisions and sought consent before delivering care and support. Where people's care plans contained restrictions on their liberty, applications for legal authorisation had been sent to the relevant authorities as required by the legislation.

Staff supported people to eat and drink enough to maintain their health and referred people to other healthcare professionals when a need was identified. Managers and staff worked with other healthcare professionals to ensure people could remain at the home at the end of their life and receive appropriate care and treatment.

Staff were caring and compassionate. They knew people well so they could deliver care in the way people preferred and in a way that was meaningful to them. The atmosphere in the home was warm and friendly and conducive to building and maintaining relationships with others in the home as well as family and friends. People's diversity was respected and staff responded to people's social and emotional needs in a person centred way. People told us their needs were met because they were supported and cared for in accordance with their wishes and choices.

People and staff were positive about the leadership of the service, staff and relatives felt the management team were visible and approachable.

The staff team worked in partnership with other organisations at a local and national level to make sure they were following current good practice and providing a high quality service. For example the registered provider and staff members attended regular conferences and workshops which looked at good practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? Lauriston remains good.	**Good**
Is the service effective? Lauriston remains effective.	**Good**
Is the service caring? Lauriston remains good	**Good**
Is the service responsive? Lauriston remains good	**Good**
Is the service well-led? Lauriston was not consistently well led.	**Requires Improvement**

Lauriston

Detailed findings

Background to this inspection

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

We visited the home on the 22, 25 and 31 January 2018. This was an unannounced inspection. The inspection was prompted in part by the high number of safeguarding and notifications received. The inspection team consisted of two inspectors and two experts by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection, we spoke with 22 people who lived at the home, seven visiting relatives, the registered manager, nine care staff, three registered nurses, the cook, two volunteers, the activity co-ordinator and the area manager. We also contacted external health professionals, such as the tissue viability nurse, GP and speech and language therapists to gain their views of the service.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home. The inspection was brought forward due to a high number of safeguardings raised which meant that the provider information form (PIR) had not been completed. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also used communication aids that people themselves used when we spoke with them..

During the inspection we reviewed records. These included staff training records and policies and procedures. We looked at four care plans from the nursing floor, one short term care plan (people who were at Lauriston for a short stay before going home) and three care plans from the dementia unit. We also looked at risk assessments along with other relevant documentation to support our findings. We 'pathway tracked' eight people living at Lauriston This is when we looked at people's care documentation in depth and obtained their views on how they found living at Lauriston. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

People and relatives all told us they felt safe in the home. Visiting relatives told us they didn't worry about safety and felt confident that people were safely cared for.

People told us they received their medicines safely and on time. One person told us, "I have no worries about how they give me my pills." People's medicines were securely stored in a clinical room and they were administered by registered nurses and senior care staff who had received
appropriate training and regular competency checks. Medicine records showed that each person had an individualised medicine administration record (MAR), which included a photograph of the person and a list of their known allergies. MAR charts indicated medicines were administered appropriately and on time (MAR charts are a document to record when people received their medicines). Records confirmed medicines were received, disposed of, and administered correctly. There was clear advice on how to support most people to take their medicines including 'as required' (PRN) medicines, such as paracetamol and mood calmers. There were however five people whose PRN protocols were not available. This was addressed immediately so the risk was mitagated. There was a clear audit trail that defined what action was taken following errors, such as medicine retraining and competency tests.

Staff had received safeguarding training and understood their responsibilities for keeping people safe from the risk of abuse. They were able to give examples of signs and types of abuse and discuss the steps they would take to protect people, including how to report any concerns. The care home had a whistle-blowing policy that provided guidance for staff on how to report concerns in the workplace. Staff told us they felt confident to whistle-blow if necessary. A member of staff said, "I would report any concerns I had, if dealt with that would be fine, but if I got no joy, I would take it up the chain until I got to CQC."

We discussed with staff how they made sure people were not discriminated against and treated equally and without prejudice. A senior member of staff told us, "I make sure that everyone is treated the same, and everyone is treated with dignity and respect. Staff are mindful of racism or sexism and respect people's differences. We are also aware that our residents may not be comfortable with staff from overseas so we do observe how staff and residents react to each other and any hint of trouble we act straight away." Staff told us they received guidance and training on equality and diversity.

People were cared for in a clean, hygienic environment. During our inspection, we viewed people's rooms, communal areas, bathrooms and toilets. The service and its equipment were clean and well maintained. The service had an infection control policy and other related policies in place. People told us that they felt the service was clean and well maintained. One person said, " It's is very clean and comfortable here." Protective Personal Equipment (PPE) such as aprons and gloves were readily available. Staff used PPE appropriately during our inspection and it was available for staff to use throughout the service.

Risk assessments were in place that identified specific risks to each person and provided written guidance for staff on how to minimise or prevent the risk of harm. Risks were regularly reviewed and updated when things changed so that staff always had access to up to date information about how to safely meet people's

needs. Staff had responded to changes in people's needs and took appropriate and timely action to keep people safe, for example, making referrals to health professionals for treatment or equipment. Staff took appropriate action following accidents and incidents to ensure people's safety, and this was recorded. We saw specific details and any follow up action to prevent a re-occurrence. Any subsequent action was shared and analysed to look for any trends or patterns.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan.

Staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. The registered manager told us how staffing levels were amended to ensure staff could attend training and ensure they were up to date with the service's policies and procedures. Management staff were also give supernumerary time to ensure that paperwork was completed in a timely manner. Feedback from people and staff indicated they felt the service had enough staff and our own observations supported this. One person told us, "They answer my bell quickly if I need help". A member of staff said, "Enough staff, but its busy in the mornings, we do get behind sometimes," and, "We all work together as a team." The registered manager said, "We monitor staffing levels every day." Documentation in staff files demonstrated that staff had the right level of skill, experience and knowledge to meet people's individual needs. Records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector.

Good

Is the service effective?

Our findings

People told us that the food was "Good" "Tasty" and "Pretty nice."

People had an initial nutritional assessment completed on admission, and their dietary needs and preferences were recorded. This was to obtain information around any special diets that may be required, and to establish preferences around food. There was a varied menu and people could eat at their preferred times and were offered alternative food choices depending on their preference. Meal times were relaxed and people were considerately supported to move to the dining areas or could choose to eat in their bedroom or the lounge.

Specific diets were catered for to support people's health needs. For example, vegetarian, diabetes, pureed and soft. An individual diet plan had been discussed, developed and agreed with the people who needed special meals. Nobody at the service required a special or culturally appropriate diet at this time but the cook confirmed that this would be sourced when required.

People said they could have something to eat or drink at any time. One person told us, "I missed out on lunch one day because I had gone out so they had made me a cold plate of food." Cold drinks were available in the lounge, dining room and people's bedrooms and, hot drinks were offered throughout the day when people wanted them, in addition to the usual mid-morning and afternoon drinks.

Staff weighed people monthly and more often if there were any concerns. One member of staff said, "We know how much residents eat and drink and that means we know immediately if they are not eating as much as usual and we do something about this straight away." GPs were contacted if staff had any concerns and referrals had been made to the dietician with advice to support people with high calorie meals or supplements.

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. 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. We checked whether the provider was working within the principles of the MCA. Staff had a good understanding of the MCA and the importance of enabling people to make decisions.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. Applications had been sent to the local authority. The registered manager understood when an application should be made and the process of submitting one. Care plans reflected people who were under a DoLS with information and guidance for staff to follow. For example, we saw that a

condition of someone's DoLS was that their medication should be reviewed frequently, with a view to reducing it, and this had been done. DoLS applications and updates were also discussed at staff meetings to ensure staff were up to date with current information.

People told us they received effective care and their individual needs were met. One person told us, "I think all the staff are excellent they can't do enough for you". Another person said, "Everyone who works here knows their job." Staff had received training in looking after people, for example in safeguarding, food hygiene, fire evacuation, health and safety, equality and diversity. The registered manager kept a training record that showed staff were provided with regular update and refresher training for topics such as fire safety, moving and handling, safeguarding, mental capacity act,
infection control and food safety. A member of staff told us, "My training is up to date either through e learning or face to face training like moving and handling." In addition, where staff needed training to meet the specific needs of people living in the home. This was provided, for example, tissue viability, wound care and catheterisation training. Syringe driver training was to be a priority going forward. Staff also told us they were able to complete further training specific to the needs of their role, and were kept up to date with best practice guidelines.

Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. They also received training specific to people's needs, for example around the care of people with dementia. Staff told us that training was encouraged and was of good quality. Feedback from staff and the registered manager confirmed that formal systems of staff development including one to one supervision meetings and annual appraisals were in place. Supervision is a system that ensures staff have the necessary support and opportunity to discuss any issues or concerns they may have.

Staff had a good understanding of equality and diversity. This was reinforced through training and the registered manager ensuring that policies and procedures were read and signed to show they were understood. Nobody living at the service had a protected characteristic, however, the registered manager explained that staff were knowledgeable of equality, diversity and human rights and people's rights would always be protected.

Staff liaised effectively with other organisations and teams and people received support from specialised healthcare professionals when required, such as GP's, community nurses and social workers. Access was also provided to more specialist services, such as opticians and physiotherapists if required. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals. One person told us, "They make sure I see the doctor when I need to, I have also been to the hospital for appointments which they never forget." Staff told us they knew people well and were able to recognise any changes in people's behaviour or condition if they were unwell to ensure they received appropriate support. Staff ensured that when people were referred for treatment that they were aware of what the treatment was and the possible outcomes, so that they were involved in deciding the best course of action for them.

People's individual needs were met by the adaptation of the premises. The service was purpose built, with safe accessible gardens and plenty of communal areas. All communal areas of the service were accessible via a lift. There were adapted bathrooms and toilets and hand rails to support people. Visual aids in communal areas helped to support orientation of people with dementia to move around the home and increase their awareness of their environment. One person told us, "The garden is nice and I like to sit there in good weather."

People were supported to live healthy and meaningful lives. People and relatives told us they did not have problems accessing the healthcare they needed. Records we looked at highlighted that staff worked closely with a wider multi-disciplinary team of healthcare professionals to provide effective support. This included GP's, behaviour therapists and a speech and language therapists (SALT) to ensure peoples accessed the right support. A GP visited the service regularly and a member of staff told us how they could always access a GP by telephone for support when needed. We saw daily records detailed how people were feeling and any changes to their health were noted and acted on. One relative told us "If they have to call the doctor, they always ring and let me know what's what." Health care professionals told us, "Very attentive staff" and "Staff are knowledgeable about the people they care for."

Good

Is the service caring?

Our findings

We received mainly positive comments and feedback from people and from relatives. People told us they felt respected and that staff were considerate, kind and thoughtful. Comments included, "Yes, they respect us and treat us all with kindness." One relative told us, "Really good care on the dementia unit, couldn't fault them, not so impressed with the nursing unit," The specific alleged issues were fed back to the registered manager with the relative's permission to investigate further.

We saw people being treated with kindness and compassion, respect and dignity. Staff were not intrusive or over-supportive but were available if needed. It was clear that staff knew people well and respected their individuality.

Everyone we spoke with told us that care staff were mindful of their privacy and dignity. We were told that staff always knocked before entering rooms. A visiting relative told us the staff always checked with the person first when they offered personal care or assistance when they were visiting. Staff told us they made sure people were fully covered and that others didn't enter rooms when they were supporting people with personal care.

People's equality and diversity was recognised and respected. People were encouraged to maintain their independence and participate in activities of their choice. One person told us, "There's something to do every morning and afternoon, but I prefer to keep myself to myself." They told us they used a mobile phone, had a radio and television and this was sufficient for their needs. Some people had a sensory impairment and staff needed to use adapted ways of communication to ensure that these people received the information they required in relation to their care, and that they could in turn express their choices and preferences. For example, one person had difficulty hearing. Staff wrote things down to convey information and ensured that they spoke clearly and slowly to their face.

People's rights to a family life were respected. Visitors were made welcome at any time and were able to have meals with their loved ones. Lounge areas were welcoming and we saw people enjoying spending time in this area with visitors during the day of our visit. Newspapers and books were available. There were items of interest from the provider, such as their vision and values, newsletters, details of events that had taken place, the weekly activities programme, health information booklets and advice about advocate services. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Staff demonstrated a strong commitment to providing compassionate care. From talking with people and staff, it was clear that they knew people well and had a good understanding of how best to support them. Staff gave us examples of people's individual personalities and character traits. They were able to talk about the people they cared for, what time they liked to get up, whether they liked to join in activities and their preferences in respect of food. Most staff also knew about people's families and some of their interests.

People looked comfortable and they were supported to maintain their personal and physical appearance.

People were well dressed and wore jewellery, and it was clear that people dressed in their own chosen style. For example, some men chose to wear casual clothes, and others wore smart outfits. Staff were respectful when talking with people, calling them by their preferred names. Staff were seen to be upholding people's dignity, and we observed them speaking discreetly with people about their care needs,. One person told us, "I can't fault them."

People who lived with dementia were treated with respect, patience and kindness. We saw staff approach people who were restless and becoming agitated with a calm, friendly and affectionate manner. The response from one person was to smile at the staff member and hold their arm and walk to the lounge area.

We read recent compliment cards and letters received in the home. They included the following, 'Thank you for all the care and support you gave us ' and, 'Thank you to all the staff and especially [names of two staff] for all the care and kindness.'

People's individual beliefs were respected. Staff understood people wanted to maintain links with religious organisations that supported them in maintaining their spiritual beliefs. Discussions with people on individual beliefs were recorded as part of the assessment process. People told us staff would arrange for a priest to visit if they wanted one. One person told us they had regular visits from their church and felt her spiritual needs were respected by staff. They told us, "I like to take Holy Communion and they arrange it."

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans showed that people and their relatives or advocates were involved in the initial care planning and the care planning review process.

Before new people moved into the home they were assessed by the registered manager or senior staff to make sure their care needs were known and staff at Lauriston had the skills to meet their needs.

Care plans were designed to reflect individual needs, choices and preferences. Care records were checked and reviewed by registered nurses or senior care staff and signed every four weeks. Care plans were formally reviewed every month with involvement of people and their representatives to check the care plans were still current and make changes if needed.

Staff demonstrated that they knew people well and supported people to have choice and control over their daily lives. For example, one staff member told us, "[Name of person] loves to sing, she's got a lovely voice." They proceeded to compliment the person who was sat nearby. We spoke with one person who was supported to move with a hoist. They told us they felt quite comfortable that staff knew what they are doing. The person said it was exceptionally important to them that they were correctly positioned in the sling as they were not able to reposition themselves. There was one occasion when they were supported by two unfamiliar members of staff. They told us this initially made them feel nervous. However, they told us they had been pleasantly surprised. The members of staff listened attentively to the person and took great care. The person said, "They worked with me and understood why I was worried about it. They didn't try to rush me and were very reassuring".

Care plans reflected people's physical, mental, emotional and social needs. For example, one person's sleep plan provided detail of their preferred time to go to bed, what they liked to wear in bed and, 'Likes her curtains left open a bit.' For another person their care plan noted when they were awake during the night they needed reassurance from staff.

Managers and staff worked with other healthcare professionals to ensure people could remain at the home at the end of their life and receive appropriate care and treatment. This included having 'anticipatory medicines' available, so people remained comfortable and pain free. End of life care plans were in place for people, which meant staff had the information they needed to ensure people's final wishes were respected. Where people had chosen not to engage in these conversations, with the person's permission, discussions had been held with family and those closest to them. One family told us that the staff on the dementia unit had been so kind, they had ensured their mother was comfortable, pain free and never left on her own. They also said the staff had looked after them as well.

A range of activities were provided. During the week of our visit, the programme included flower arranging, exercises, musical events, 'story telling' sessions, cinema and quizzes. People were also supported with one to one support in their rooms by volunteers. We observed a music afternoon taking place in one of the lounges. People from all units joined this activity.

Care staff and activity staff encouraged and enabled people to participate as much as they were able. One person said "I enjoy the activities." Regular meetings had been held to discuss the activities programme and to discuss ideas and suggestions. We read the minutes from the most recent meeting. People had requested trips out and about, which we were told were being planned. We were made aware that changes were happening as the activity person was leaving the service. The registered manager was committed to ensuring that this would not impact on the activities within the service. The area manager confirmed that they had support plan in place.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. The registered manager was familiar with AIS and they had identified the communication needs of people. Communication was part of the individual assessment tool completed for each person. Any needs identified to facilitate communication were recorded and responded to. For example, one person had poor sight and staff were told to approach them slowly, calling their name so as not to alarm them. Staff took account of people's hearing aids and glasses making sure they were available, clean and working. The registered manager confirmed information on the service could be made available in larger print if required.

People were sensitively supported to communicate in ways that were meaningful to them. For example, one person with cognitive difficulties was supported by a member of staff. The member of staff clearly understood how to communicate effectively with the person who they supported to participate in a group activity.

A complaints procedure was in place that was readily available to people and relatives. The procedure was displayed in the reception area and given to people as part of their welcome pack when they moved into the home. We looked at the complaints file and saw that complaints managed in accordance with the provider's policy. We read the details of a recent complaint and the actions required had been checked and followed up by the registered manager at one of the daily head of department meetings. The people and relatives we spoke with had not had a reason to make a complaint, but felt confident they could do so if needed. One relative arranged a meeting with the registered manager, during our visit.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff spoke highly of the registered manager and felt the service was well-led. Staff commented they felt supported and could approach the registered manager with any concerns or questions. A registered manager was in post and supported by a deputy manager and full staff team. There was also support from the area manager.

The provider undertook quality assurance audits to ensure a good level of quality was maintained. We saw audit activity which included health and safety and medication. Despite these audits we found that some development of systems was needed and requires improvement. For example medication audits had been undertaken and identified that 'as required' (PRN) protocols were needed. However we found that seven people on the dementia unit had no protocols for their PRN medicines and no pain charts that assisted staff in recognising symptoms of pain. This was immediately actioned by the senior care staff member on the first day of the inspection and risk was mitigated. We also found that some people were on continued bed rest without a risk assessment framework that enabled them to participate in activities of their choice. This was taken forward by the deputy manager for discussion with nurses about managing risk without impacting on their choice. There had been an increase in safeguarding alerts over the past eight months. These were recorded and reported to the local authority and CQC but lacked root core analysis and follow through to demonstrate learning from these situations. Root cause analysis is a collective term that describes a wide range of approaches, tools, and techniques used to uncover causes of problems.

People living at the home, relatives and staff were complimentary regarding the management and leadership of the home. People told us the registered manager had a visible presence and was approachable. Their comments included, "The whole staff team are so good and its well run." "Very nice people and they will listen to anything you've got to say" and "All the staff are kind." I think it is very well run here." When discussing the management of the home a relative told us how impressed they had been with the way their concerns had been managed, "I was listened to, and involved in decisions going forward."

The service had a clear vision and focus to provide person-centred care with the service's ethos based around, 'residents always come first'. The registered manager said, "This is their home and we want people to feel that they have what they would have at home, as far as we can.' Feedback from people, staff and visitors was sought regularly through resident meetings and surveys. A recent survey had been undertaken about the meal service. This had identified that there is some dissatisfaction about the meals. This was being further investigated and meetings with people and the kitchen staff arranged.

We talked to the staff about the ethos of the home. Staff were positive about the culture being open, transparent and supportive. Staff told us they attended staff meetings and could share their views with the registered manager. A staff member reported, "(Registered manager) is open to contact any time."

Staff told us they felt fully supported in their job role and valued by the management team. A staff member told us how much they enjoyed working at the home and that it was "Agood place to work."

Staff had access to policies and procedure, for example, whistle blowing, safeguarding, infection control, health and safety, in accordance with best practice and current legislation. This helped to promote the safety and quality of the service along with quality assurance systems and processes to maintain and drive forward improvements. Staff had a good understanding of equality, diversity and human rights gained through training and detailed policies and procedures. Feedback from staff indicated that the protection of people's rights was embedded into practice. Up to date sector specific information was also made available for staff, including guidance around the Mental Capacity Act 2005 and updates on available training from the Local Authority. The service had also liaised regularly with the Local Authority, the Dementia In-Reach Service and Clinical Commissioning Group (CCG) in order to share information and learning around local issues and best practice in care delivery. The registered manager told us, "We are always looking to learn and develop."

We saw evidence that the service worked effectively with other health and social care organisations to achieve better outcomes for people and improve quality and safety. The health and social care professionals we contacted did not express any concerns at the time of our inspection. External health care professionals we contacted informed us the service was well managed and people received a good standard of care.

The Care Quality Commission (CQC) had been notified of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding Lauriston. The manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

From April 2015 it was a legal requirement for providers to display their CQC rating. The rating from the previous inspection for Lauriston was displayed for people to see.