The Laurels Care Centre Limited

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Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection was carried out on 8 June 2016 and was unannounced.

The Laurels Care Centre Limited is registered to provide nursing care for up to 63 people. The home has three units, two of which provide care for people who have dementia. The third unit provides care for people with general nursing needs. The home is accessible to people who use wheelchairs and parking is available. A lift allows access to all floors of the building. When we visited 54 people were using the service.

The previously appointed registered manager left the home in May 2016. The deputy manager has been managing the service in the absence of a permanent post holder. 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 service was last inspected on 11 and 19 January 2016. At that inspection we found two breaches of regulations. They related to safe care and treatment and the need for the provider to establish systems to monitor and mitigate the risks to people in the home. We also made a recommendation about staff being provided with advice and guidance about how to assist people properly at mealtimes. This was a focused inspection to follow up progress on these issues.

At this inspection we found three regulations were breached. The provider had failed to address one of the previously identified breaches of regulation and establish systems to effectively mitigate the risks to people at the home. We also found that when people needed to have a record made of their food and fluid intake accurate and complete records not were kept. People's privacy was not protected by staff. We observed an instance of a staff member showing a lack of kindness towards a person. The provider did not display at the home or on their website the rating awarded to the service at the last inspection.

We are considering the action to take in response to the breaches.

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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 was not safe. A communal area had an unpleasant smell of stale urine and furniture was stained and in poor condition. This put people at risk of infection and had a negative impact on their quality of life.

Is the service effective?

Requires Improvement

The service was not effective. Records of food and fluid intake were inconsistent and incomplete and did not contribute to supporting people to eat and drink enough.

Is the service caring?

Requires Improvement

The service was not caring. People's privacy and dignity was not protected. We observed an instance where staff showed a lack of compassion in their interaction with a person.

Is the service well-led?

Requires Improvement

The service was not well led. The provider had not displayed the CQC rating of the service at the home or on their website as required. at the last inspection we told the provider about ways in which they had not met regulations. Insufficient action had been taken to address these matters.

The Laurels Care Centre Limited

Detailed findings

Background to this inspection

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

The inspection took place on 8 June 2016 and was unannounced. Two inspectors carried out the inspection.

We reviewed the information we held about the service including records of notifications sent to us. We spoke with three people who lived at the home and observed staff interaction. We spoke with nine staff, including, the manager, area manager, deputy manager, nurses and care staff.

While we were at the home we undertook general observations in communal areas and during a meal time. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at personal care and support records for five people. We looked at other records relating to the management of the service, including notifications, audits and fire safety records.

Before the inspection with spoke with a health and social care professional about their experience of the home.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in January 2016 we found that the home was not safe. This was because there were parts of the building that had an unpleasant odour, were unhygienic, and could have put people at risk of infection. Some staff were not familiar with the operation of a fire exit door and this could have put people at risk in an emergency. Risk assessments were not always up to date or followed by staff to manage risks. Staff did not always follow people's management plans to reduce risks to their health. As a result of these issues the home was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had made some improvements, but not all of our areas of concern had been addressed sufficiently. The provider sent us an action plan to inform us that action would be taken to address the concerns by 31 May 2016. We found that some redecoration and replacement of carpets had been completed. This made the areas where this has been done look fresher and they were easier to clean. However we found that communal areas on the first floor remained unhygienic. There was an unpleasant odour of stale urine in communal areas . We saw chairs and a sofa that were stained. We also saw a chair was damaged and some of the seat base was hanging down. These items of furniture were due to be replaced. The unclean, damaged furniture put people at risk of infection and had a negative impact on their quality of life because they had to spend time in rooms that had an unpleasant odour. The manager told us after the inspection that the work was to be done but they did not have a date by which it would be complete.

This was a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection people were at risk in the event of a fire because staff were not familiar with the operation of a fire exit door. This may have delayed the safe evacuation of people in an emergency. At this inspection we found that staff were familiar with the fire procedure and knew where the emergency exits were and how they operated. People told us they heard the fire alarms being tested regularly. We saw a door to a toilet on the first floor which was damaged and we were concerned that this could have made fire safety arrangements ineffective. After the inspection we spoke with the newly appointed manager of the home and he informed us the door was being repaired on the day we called.

At the last inspection we found that people did not benefit from equipment to manage their risk of developing pressure ulcers because some items were not used properly and others were in poor condition. Two pressure relieving mattresses were on settings that were not appropriate for the people using them. The settings were meant to reflect the weight of the person using the bed and this was not the case. We saw pressure relieving cushions that were not fit for purpose as they had become thin so did not provide protection and were ineffective. At this inspection we found that mattresses were on the correct settings for the person using them and cushions were in good condition. A system to check the mattress settings and cushions regularly had been introduced and checks were recorded.

At the last inspection we found staff had not observed a person's need to wear well-fitting footwear to minimise their risk of falls. At this inspection we saw people were wearing appropriate footwear and this concern had been addressed.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in January 2016 we found the home was not effective. This was because people did not always receive support at mealtimes from staff who understood how to meet their needs. Staff had not provided people with plate guards that assisted them to eat independently. We also observed that when a member of staff assisted a person with a meal they did so in a way that did not enable communication between them. In response we made a recommendation that the service provide advice and guidance from a reputable source, for staff, about supporting people effectively with meals.

People were assisted at meals by staff who understood how to meet their needs and took notice of advice on how to do so. At this inspection we observed that a member of staff fitted a plate guard to assist a person with their meal. We saw a person being assisted by a member of staff who was standing while they helped them and this position did not allow good communication between them. We heard the acting deputy manager instruct the staff member to sit down while they were assisting the person. The staff member did so.

People were supported by staff who monitored their weights and took action when necessary, for example making referral to specialists for advice. Prior to out inspection we had received concerns that there had been poor monitoring of weight loss. However records of people's food and fluid intake did not support people against the risk of malnutrition and dehydration. We looked at records of people's food intake. On each of the records there was a section that stated "reason why this chart needs to be completed", it was not completed on any of the charts we saw. We were concerned that staff did not know why the food and fluid record was maintained and did not understand the importance of the record in monitoring people's care.

People were not supported by records of their food and fluid intake because they were inconsistent and incomplete. This meant staff could not use records to support people with a diet that met their needs. For example the records did not allow staff to give people additional snacks if they had eaten poorly at a mealtime. They also could not use the records to identify foods people ate well and use this understanding of their preferences.
On the first floor of the home we noted that for some people food and fluid intake charts for breakfast and lunch were completed for the day at approximately 3pm. The acting deputy manager agreed that they should have been completed close to the meals being provided for people so accurate records could be made. On the second floor we asked to see food and fluid intake records for a person who, we were told by a nurse had a low weight. Staff provided records for the 1st, 7th and 8th June 2016 (the day of our visit). The record for 1st June 2016 did not have any entries after 9 am that day. There was no written explanation for this and the staff could not tell us why the record was incomplete. Staff could not tell us why the records for 2nd to 6th June were not available. The record for 7th June contained entries for throughout the day and that for 8th June included entries for breakfast and lunch and drinks in between the meals. The records did not give evidence that staff supported people with their nutritional and hydration needs.

This was a breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in January 2016 we found that the home was not caring. This was because personal information about two people living at the home was on a notice board in a communal area although it should have been kept confidential. At this inspection we found that no personal information was displayed.

However, staff did not respect people's privacy. We passed a bedroom which had the door open wide and saw a person asleep on a bed. Initially the person was covered by a blanket. It was a warm day and when we next passed the room the person was not covered by bedclothes. They were wearing thin cotton nightwear and their privacy and dignity were not respected. The person was visible in this condition for at least 90 minutes. We believed that a member of staff had been in the room because a meal was placed on a bedside table, remained there uneaten and was later removed. The person was left in an undignified situation and reasonable steps had not been taken to rectify this and protect the person.

People were not always treated in a caring way. We saw many instances of staff being kind and caring. However we observed an interaction between a person and member of staff that demonstrated a lack of care and understanding of dementia and how to communicate with people with the condition. We heard a person talking with a member of staff, but did not hear the content of the conversation until the member of staff said, "Your [family member is] dead. I am sorry but that is reality." This statement displayed a lack of care, compassion and empathy.

We asked the staff member if they had received training in dementia and communication with people with the condition. They said they had but said they needed to have more training in the condition. When we discussed this matter with managers they agreed that the statement was unacceptable. They stated there had been training in dementia recently which staff attended.

These matters were a breach of Regulation 10(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in January 2016 we found the home was not well led. Although the manager and operations manager carried out quality and safety audits, the issues we found regarding risks to people's safety had not been identified during the internal audits. Managers had a plan in place to address matters through redecoration and refurbishment. Nevertheless basic standards of hygiene and safety were not maintained until the work was complete.

This was a breach of Regulation 17(1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that some areas had improved as a result of redecoration. However the planned refurbishment was not complete, and there remained an unpleasant odour of stale urine in communal areas. The acting manager told us they had submitted a request to the provider for new items of furniture and for the replacement of carpets should continue. But this had not taken place. They told us the nominated individual had visited the service to see the building and the need for refurbishment, but nevertheless the changes had not taken place.

The registered provider did not meet the requirements of their registration with the Care Quality Commission. Registered providers are required to display the rating awarded to a service after an assessment of the regulated activity. The rating must be displayed at the home and on their website. The rating we awarded in the published report of the last inspection in January 2016 was not displayed at the home or on their website. After the inspection the manager told us they had displayed the rating in the home.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure that people who used services were treated with dignity and respect by maintaining their privacy at all times, including when they are asleep.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not maintain securely an accurate, complete and contemporaneous record for service users who required their food and fluid intake to be monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider did not ensure that their rating was displayed conspicuously and legibly at the location delivering a regulated service and on their website.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Communal areas on the first floor remained unhygienic. There was an unpleasant odour of stale urine in communal areas . We saw chairs and a sofa that were stained. We also saw a chair was damaged and some of the seat base was hanging down. These items of furniture were due to be replaced. The unclean, damaged furniture put people at risk of infection and had a negative impact on their quality of life because they had to spend time in rooms that had an unpleasant odour.

The enforcement action we took:

warning notice