

Defiant Enterprises Limited

The Laurels Care Home

Inspection report

The Laurels
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29 January 2021

03 February 2021

05 February 2021

10 February 2021

22 February 2021

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23 August 2021

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

The Laurels care home is a residential care home which provides nursing and personal care for up to 52 people aged 65 and over. At the time of the inspection, there were 42 people living in the home. The home is a purpose built one storey building.

People's experience of using this service and what we found

People were not sufficiently protected against the risks associated with the current COVID - 19 pandemic as infection prevention and control procedures had not been effectively implemented.

We found that staff competency in the administration of medicines was not always sufficient and we observed some unsafe practice. Other aspects of medicines management were however safe.

Care plans and peoples care records did not always accurately reflect or assess potential risks to people so that staff could support them safely. Management oversight of these risks did not identify themes or trends so that action could be taken if required.

The providers recruitment process had not been followed. Some staff had been recruited without all the necessary checks being completed. Supervision of newly recruited staff was sparse and did not contribute to assessing whether they were suitable in their role and understood what was required.

Enough staff were employed in order to meet people's needs and keep them safe, however these staff were not effectively deployed to ensure people needs were met in a timely manner. Peoples feedback was that they sometimes had to wait long periods of time to receive care. The registered manager did not review staffing needs across different times of the day so that they could see if people's needs were being met.

Staff understood safeguarding procedures and how to report concerns. They were able to describe to us what they should be observant for and the types of abuse vulnerable people were prone to.

Oversight and management of the service had been insufficient, it had not identified the shortfalls we found on inspection. The registered manager had not implemented an overarching quality assurance system to ensure good and safe care was provided to people. The service had failed to make improvements since the last inspection. People and their relatives felt that the service lacked a managerial presence, and limited information had been shared with them during the pandemic at a time when visitation was difficult.

During the inspection, the registered manager started to take positive action to address these concerns.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was requires improvement (Published 4 September 2019). The service remains rated requires improvement. This service has been rated requires improvement or inadequate for the last nine consecutive inspections.

Why we inspected

The inspection was prompted in part due to concerns received about infection prevention and control. A decision was made for us to inspect and examine those risks. During this targeted inspection, we identified further concerns relating to medicines management and leadership within the home, so we widened the scope of the inspection to a focused inspection of the key questions of safe and well-led.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

The overall rating for the service has remained requires improvement. However, we have changed the rating for our well-led question to Inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Laurels Care Home on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the safe administration of medicines, infection prevention and control, fit and proper persons employed and good governance this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate ●

The Laurels Care Home

Detailed findings

Background to this inspection

The inspection

We carried out this focussed inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

This inspection was carried out by three inspectors, one of which is a member of the CQC's medicines team. An Expert by Experience spoke to service users and their relatives via telephone. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

The Laurels Care Home 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection, we sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with five members of care staff, a housekeeper, the registered manager, the providers managing director and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records, this included 15 peoples care records and multiple medicines administrations records. We looked at three staff files in relation to recruitment and staff supervisions. A variety of records relating to the management of the service, including audits, policies and procedures were reviewed.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- We observed a medicines round in progress however, during our observation we identified unsafe practice. This included the staff member allowing themselves to be interrupted by other staff, people living at the home and answering the door to visitors when other staff were available to do this.
- The staff member did not follow infection prevention and control (IPAC) procedures including washing their hands and was not wearing personal protective equipment (PPE), when attending to a person requiring barrier nursing due to the risk of the spread of infection.
- They also had not prepared themselves adequately and did not have enough equipment such as spoons or pots available and no bin bag to dispose of items. We observed that the staff member did not use a clean medicines pot or spoon for each person. The medicines trolley surface was visibly unclean and had not been wiped down. The staff member used this as a tabletop to tip medicines onto.
- The staff member did not follow the providers expected practice of moving around the home with the medicine trolley room to room and was observed carrying armfuls of bottles and boxes of medicines with them. They had left the electronic medicines administrations records behind with the trolley the medicines were stored in, meaning that these were given without checking the records at the point of dispensing. This is not safe practice.
- We also noted there were gaps in records for medicated skin-patches applied to people's bodies that should have confirmed they were applied to different areas in rotation. This avoids the possibility of adverse skin-contact effects that might occur when patches are frequently applied to the same sites.
- This meant people were at risk of receiving the wrong medicines as well as the risks presented to them by unsafe IPAC practice.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider responded immediately during and after the inspection to ensure that the administration of medicines in the home was reviewed to ensure it took place safely.

Preventing and controlling infection, Assessing risk, safety monitoring and management, Learning lessons when things go wrong

- The registered managers oversight of IPAC during the pandemic had not been sufficient, they had not reviewed systems or implement audits and checks of practice to meet latest guidance.
- Cleaning schedules had not been enhanced in light of the Covid-19 pandemic. Cleaning staff only worked between 7am and 2pm. There were no fixed arrangements for cleaning to take place after this. Touch points

and handles were only cleaned twice a day. We observed toilets remained dirty even after they had been visited by a cleaner.

- On the first day of our inspection the head of care told us there were two cleaners on duty, whereas in fact there was only one. This had not been identified at the morning staff handover. Records showed us that on two occasions during the previous two weeks, there had been no cleaner on duty and cleaning had not taken place on these occasions.
- We identified poor staff IPAC practice. We observed staff serve biscuits and cakes using their fingers rather than serving tongs. We also observed one member of staff not wearing their face mask over their nose in a food preparation area. Changes to the seating plan in communal areas had not taken place so that people could be socially distanced, we observed people sitting very close to each other.
- We observed that for one person who required barrier nursing, some staff provided care without wearing PPE. We also found that supplies of protective gloves for staff to use when caring for this person were not available for use in their room. When we asked staff which people required barrier nursing, of which there was currently two, some staff told us they were not aware that anyone was.
- The registered manager had failed to implement a system to protect people from the additional risks posed by the COVID -19 pandemic. One person at additional risk because of their black and minority ethnic heritage had not had their care plan reviewed to include the additional risks.
- There were gaps in records to show that people had enough to eat, drink or manage their skin integrity and changes of position.
- Care records were inconsistent and contradictory in relation to people's agitation or distress and how this presented.
- Monitoring tools and audits to be used by the registered manager to review incidents and accidents, including pressure areas and falls were insufficient to monitor and review. These only provided summary totals of incidents with no ability to look into themes or patterns.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm.

This was a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had implemented a regular COVID-19 testing regime for staff. This included weekly swab testing and twice weekly Lateral Flow Tests (LFT). This was to enable the provider to identify positive cases of COVID-19 where no symptoms were displayed.
- There was a visiting room with a screen in place to enable people to receive visits from their relatives. There were measures in place to reduce the transmission of infection and to keep people safe. For example, all visitors entered by an external door to the room, hand gel and PPE was provided.

Staffing and recruitment

- We identified that the providers recruitment process had not always been followed. Records we reviewed showed that peoples full employment history had not been obtained so that any gaps could be explored. We also saw that references had not been requested for previous jobs in care for one staff member.
- Interview notes were brief and did not demonstrate that every effort had been made to ensure that the applicant was suitable to work in social care. New staff had received minimal supervision meetings during the first months of employment to ensure that they could achieve what was expected of the role.

This was a breach of regulation 19 (Fit and Proper Persons Employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We received mixed feedback from people living at the service as to whether there were enough staff deployed. Some people felt that there were not enough staff as they had to wait excessive amounts of time at certain periods of the day. Some people felt that the deployment of staff needed improvement to ensure enough staff were available.
- Staff rotas showed that there were enough staff on duty to meet the assessed level of need. However, we found that sufficient attention had not been paid as to how and when these staff were deployed. The registered manager had not reviewed how the needs of people varied at different parts of the day.
- We received mixed feedback from staff. Some staff felt more staff were required in order to meet people's needs in a timely way. Other staff felt that co-ordination of staff needed improvement. This included the covering of breaks, handovers and mealtimes.

Systems and processes to safeguard people from the risk of abuse

- People told us that they felt safe. One person said, "Yes, I feel safe. At night they do regular patrols from night staff. There are fire and safety checks. There is someone there for you."
- Systems were in place to protect people from the risk of abuse. Policies were in place about safeguarding adults and whistleblowing. We saw that any safeguarding allegations had been dealt with in line with the policies.
- The registered manager and other staff had undertaken training about safeguarding adults and were aware of their respective responsibilities with regard to this.
- Staff were able to describe to us the types of abuse people living at the home were vulnerable to, and what could be done to help protect them from this.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, Continuous learning and improving care

- The registered manager and provider had not recognised the quality of the service had deteriorated. They did not have adequate systems in place to monitor and review the quality of care and ensure the service was meeting people's needs safely and effectively. They had therefore put people at risk of unsafe care. This inspection was the ninth consecutive inspection where it had failed to achieve an overall rating of good.
- Oversight and governance by the registered manager was not sufficient. Spot checks and quality assurance checks were reported to have been completed but informally only, with minimal record of this. The registered manager had not created a culture which promoted high quality care or strive to achieve this.
- Audits and checks did not look for themes or trends that could reduce risks or contribute to service improvement. The registered manager lacked an understanding to implement an overarching quality assurance process. They had not identified the issues we found during the inspection.
- The registered manager and provider failed to ensure infection control was well managed in the home. For example, they had not ensured there were cleaning schedules and cleaning staff in place.
- Some staff felt the registered manager did not have a physical presence in the service, which was also noted to us by people. The registered manager told us that they did not routinely attend staff handover meetings. Records showed that team meetings had only taken place twice in a year.
- People and relatives told us that the registered manager did not engage with them regularly in person or by other means. Some relatives told us they had not been told about the use of a visitor pod or other visitor arrangements during the pandemic. One person told us, "I have not seen her [registered manager] since Christmas. I saw her once between September and Christmas. She says, 'If you have got a problem come and see me.' I believe it would be beneficial for her to get about more." A planned newsletter to families who could not see their relatives had not been implemented.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Relatives of people we spoke with told us that staff contacted them if something had gone wrong and explained in detail what had happened. This provided reassurance to relatives who were unable to visit for

long periods.

- During and following our inspection, the providers nominated individual worked openly and honestly with inspectors to listen to feedback and concerns. They took immediate action to address and swiftly update inspectors with progress.

Working in partnership with others

- Following our inspection, the providers nominated individual was engaging with the local authority quality assurance team to improve the management of the service.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Regulation 12 HSCA RA Regulations 2014 Safe Care and Treatment Care and treatment was not always provided in a safe way. Risks to people's safety who were living in the service had not always been assessed. Where they had been, actions had not always been taken to mitigate these risks. Action had not been taken to ensure the risk of the spread of infection was minimised. Medicines were not always administered safely. Regulation 12, 1 and 2 (a), (b) (d), (e), (g) and (h).</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>Regulation 19 HSCA RA Regulations 2014 Fit and Proper Person Employed The registered manager had not ensured that systems to ensure fit and proper persons were employed had been implemented</p>

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	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess monitor and improve the quality and safety of the service provided and to assess monitor and mitigate risks relating to the health, safety and welfare of people living in the service were not effective. An accurate and complete contemporaneous record in response of each person living in the service was not in place. . Regulation 17, 1 and 2 (a), (b), (c), (e) and (f).

The enforcement action we took:

We issued a notice of proposal to impose positive conditions.