Defiant Enterprises Limited

The Laurels Care Home

Inspection report

The Laurels
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Date of inspection visit:
27 November 2017
29 November 2017

Date of publication:
23 January 2018

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The Laurels Care Home is a care home that provides accommodation and personal care for up to 52 people. The provider's website describes the service as one that 'specialises in round the clock dementia care and care for frail people.' 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. At the time of our visit the provider was supporting 29 people, the majority of who were living with dementia.

There was a registered manager working in the home. 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.'

At our last inspection in July 2017 we rated this home overall as Requires Improvement. After this inspection that overall rating has been reduced to Inadequate.

This inspection site visit took place on 27 and 29 November 2017. The first day was unannounced. It was conducted in response to concerns we had received since our last inspection in July 2017, about the quality of care people were receiving. The concerns related to staffing levels, continence care, staff training/competency, cleanliness and infection control practices and bruising that some people had sustained. As these concerns related primarily to people's safety, we decided to inspect the following two key questions: is the service safe and is the service well-led? No risks, concerns or significant improvement were identified in the remaining key questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection.

At our last inspection in July 2017, we found three breaches of legal requirements within the safe and well-led key questions. This was because the provider had not ensured the care people received was safe or that all equipment and areas of the premises were clean. They had also failed to ensure that robust governance processes were in place to effectively assess and monitor the quality of care people received.

We asked the provider to complete an action plan to show what they would do and by when to meet these legal requirements. They told us these would be fully met by 10 October 2017. As they told us they would be meeting these requirements at the time of this inspection, we checked to see if improvements had been made. We found that the required improvements had not been made and that the provider continued to be in breach of these three legal requirements.

In addition, we found two further breaches of legal requirements. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and

appeals have been concluded.

Staff understood how to reduce the risk of people experiencing abuse. However, some risks to people's safety had not been adequately managed or reviewed to ensure that all necessary actions were being taken to keep people safe. This placed people at risk of avoidable harm.

The registered manager or provider had not effectively monitored staff practice and competency to perform their role safely. This resulted in some staff performing care tasks without first receiving the necessary training, resulting in poor care practice that placed people at risk of unsafe care.

People's medicines were poorly managed. Accurate records had not been kept and therefore, the provider could not give themselves assurance through their existing auditing systems that people had received their medicines correctly.

The provider had assessed the number of staff that were required to meet people's needs and to keep them safe. However, these numbers had not been consistently met. Therefore, people sometimes had to wait for the care and support they required. This had in the main, been due to high levels of staff sickness that the registered manager and provider were actively trying to resolve. We saw this was reducing but continuing improvements are required.

Since December 2014, the provider has not been able to achieve a rating of Good. There have been a number of regulation breaches over this time and where any improvement has been made, the provider has not always been able to maintain this. At this inspection we again found that the provider's governance systems were not robust enough to drive improvement and to monitor and assess that people received a level of good, safe care.

The provider or registered manager had not notified the CQC of certain incidents that had taken place within the home, as is required by law.

There was an open culture in the home where people and staff felt able to raise concerns without fear of recrimination. However, not all staff felt consistently valued or appreciated.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Some risks to people's safety had not been adequately assessed or managed.

Some staff had not received appropriate training or supervision prior to them working unsupervised.

The number of staff working each day had not always met the provider's own requirements although this was improving.

Records did not support that people had received their medicines correctly.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to ensure that existing governance systems were effective at monitoring the quality of care provided or to mitigate risks to their safety.

The CQC had not been notified of all incidents as were required by the regulations.

There was an open culture in the home but improvements are required to the leadership of the home to in-still a culture of inclusion and to help staff feel valued.

The Laurels Care Home

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.

Following our last inspection of this home in July 2017, we received a number of concerns relating to the quality of care people were receiving. The concerns related to staffing levels, continence care, staff training/competency, cleanliness and infection control practices and bruising that some people had sustained. This resulted in us making some referrals to the local authority safeguarding team. We conducted this inspection to ensure people were receiving safe care.

The inspection took place on the 27 and 29 November 2017. The first day was unannounced. The inspection team consisted of two inspectors and an expert 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.

Before the inspection, we reviewed information that we held about the home. This included any information we had received from the public or third parties such as the local authority. We also reviewed notifications the provider had sent us since our last inspection. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters.

During the inspection visits, we gained the views of six people living in the home and three visitors about the care that they or their relative received. We spoke with five staff, the registered manager and a representative of the provider. Some people living in the home were not able to communicate their views to us, therefore we spent time observing how support was provided to them.

The records we looked at included five people's care records, 29 people's medicine records, four staff recruitment files, staff training records and records in relation to the safety of the premises. We also looked at documentation showing how the provider assessed the quality of the service they provided.

Inadequate

Is the service safe?

Our findings

At our last inspection in July 2017 we rated Safe as Requires Improvement. At this inspection the safety of the service had declined. Therefore, we have rated Safe as Inadequate.

At our previous inspection in July 2017 we identified a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that risks to people's safety had always been assessed or were being adequately managed. At this inspection we found that sufficient progress had not been made in this area and therefore, the provider continued to be in breach of this Regulation.

On the first day of our inspection, the registered manager told us there had been a fire in the home a few days prior to our visit. This had occurred because a person living in the home had accidentally got hold of a lighter and set fire to a curtain. The staff had dealt with the fire and no one had experienced any harm. The registered manager had assessed that the person having a lighter was a risk to themselves and others. Therefore, they had put in place a set of control measures in to prevent them from independently having a lighter. However, the staff member from whom the person obtained the lighter by accident had not been told of these control measures and therefore, had not followed them. Had they done so, the incident may have been prevented. This lack of communication had placed people at risk of avoidable harm.

During our walk around of the premises, we again found some exposed pipework within communal areas that were very hot to the touch. This was the third inspection in a row that we had identified this as an issue. One of these areas was the communal dining room. A senior member of staff told us that one of the people using this area was at high risk of falls. We were concerned that should anyone fall near the pipework they could become entrapped between the pipework and a dining room table. Not covering this pipework placed people at unnecessary risk of burns. On the second day of our inspection visit, these had been covered.

Toiletries such as deodorants, bubble bath and shaving foam were found either in communal bathrooms or people's rooms. The registered manager told us they had not assessed whether leaving these items unsecure was safe for the people living in the home who might accidentally ingest or misuse these items.

A bottle containing an unidentified substance was found on a trolley in a communal corridor. There were no staff present at the time. We saw the bottle had some black ink on it but we could not read what the substance was. This is poor practice and not in line with the Control of Substances Hazard to Health (COSHH) regulations. We were concerned about this as a person living with dementia regularly walked past the trolley. We had seen them earlier in the day randomly picking up items to take away with them. This posed an unnecessary risk to the person and others as they could have taken the bottle without staff knowledge. We asked the deputy manager what was in the bottle. They told us it was disinfectant. The deputy manager removed the bottle and said they would securely lock it away.

The registered manager told us that one person had a portable heater in their room that they could use if they wished. The registered manager had not assessed whether it was safe for the person to have this heater

in their room. For example, they had not ensured the person understood any risks associated with using the heater. Also, they had not provided any guidance to staff about where to place the heater so it was not a trip hazard. We found a fan heater in another person's room. The registered manager told us they did not know that it was there and therefore, any risks associated with its use had not been conducted. They later removed this heater from the person's room.

Two people were observed to have their call bell out of their reach. Therefore they could not easily alert staff if they required assistance. We checked one person's care record. This specifically stated that the person required access to their call bell at all times to enable them to request support from staff when needed.

Risks in relation to people falling were not always been managed appropriately. During the morning on the first day of our inspection, we observed that one person had spilt their drink on the floor. The staff did not notice this and this remained the same for 55 minutes. During our observations we made sure people were safe and alerted staff to the issue who then took action to clean up the spillage. If we had not been present, this would have posed a risk of falls to people.

In October 2017, the registered manager had assessed one person as being at risk of falls. The person's records showed that since that date, they had experienced a further three falls. However, these falls had not prompted a review of the person's risk assessment to ensure that all actions being taken to mitigate the risk were appropriate. Furthermore, we found that one fall had not been brought to the registered manager's attention. Therefore they had not conducted an investigation into this fall to ascertain whether further action was required to protect this person from the risk of avoidable harm.

Accident records that had been completed following falls showed that staff had not always taken appropriate action to keep people safe. One person's accident record stated they had redness under their eye following a fall. For the same incident, it had been recorded in the person's falls diary they had a bump to their head. However, staff had not sought any medical advice until two days later placing the person at risk. On two other accident forms, staff had recorded that people had been moved even though they had complained of pain. This is poor practice and can result in an exacerbation of injury. This action was also against the provider's own policy. We saw that one of these people had seen a medical professional the following day who had advised the person required an x-ray. A fracture had subsequently been diagnosed.

Risks in relation to people's skin integrity had been assessed but had not always been reviewed or updated when appropriate. Actions had not always been taken where needed to protect people from an identified risk. One person had experienced significant pressure sores on their heels which were now healing. Their risk associated with this had not been re-assessed since September 2017 to ensure that all necessary actions were being taken to reduce this risk as much as possible. Another person who was in hospital at the time of our inspection, also had a significant pressure sore on their body. Again, the risk associated with this area had not been re-assessed since September 2017.

We heard one person calling out for assistance. This person was sitting up in their chair. When we visited this person we saw there was some pressure relieving inflatable boots standing up as a pair on the other side of the room. We asked a member of staff to attend the person. The staff member left the person's room without fitting these boots. We therefore asked them whether the person should be wearing these as records had shown they had two pressure sores on their heels. The staff member told us they should and duly placed them on the person's legs with their consent. Failure to use the pressure relieving boots increased risks to the person's safety from their pressure sores deteriorating.

We looked at the care records in relation to the three people above to see what actions staff needed to take

to manage the risk in relation to pressure sores. We found there was insufficient guidance in place for staff. None of the relevant care plans stated all of the equipment people needed to have in place to reduce this risk. For the two people who had specialist boots, this was not mentioned in their care plan. There was no information to advise staff how often they needed to support people to re-position themselves. In addition we also found there was a lack of information in one person's care record in relation to what actions staff needed to take to manage their nutritional risk. For example, it was noted in their care record that they required a soft diet. However, a speech and language therapist had stated they should eat a normal diet due to the risk of them not eating soft food and therefore losing weight. This information had not been recorded within the person's care record. As the home frequently used agency staff who may not have been aware of the risks to people's safety, it is important that clear and accurate guidance was in place that they could refer to when needed. As this was not the case this increased the risk of people not receiving the correct care to keep them safe.

Although staff stored medicines securely for the safety of people living in the home, other aspects of medicine management were not as safe as they should be. We found gaps within 11 people's medicine records and in some, discrepancies in stock levels. This did not support that people had received their medicines as intended by the person who had prescribed them.

For example, it had been recorded for one person that for a medicine they had been prescribed twice a day that 17 were in stock after they had received their dose on 23 November 2017. If these had been given correctly then on the first day of our inspection, there should have been eleven tablets left in stock. However, there were 13 which implied that two doses had possibly been missed.

For another person, we found there were two tablets left over but that if they had all been given correctly as prescribed, there would have been none left. There was a gap in the medicine record for the day before our inspection and therefore, we concluded the person had not been given this medicine correctly.

A further person had missed an evening dose of the pain medicine. This had been identified as an error by a senior member of staff and the agency staff member who missed the dose, had subsequently been assessed in relation to their competency to give medicines. However, the error had not been recorded as an incident and therefore not brought to the attention of the registered manager for a full investigation.

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

Following the fire incident, the registered manager advised they had put in place further controls and communicated this to all staff. This action had been taken to try to reduce the risk of the incident from re-occurring. After the inspection visit, the provider told us the person who we had raised concerns about in relation to their nutritional risk had documentation in place to guide staff to offer a normal diet with softer options although we did not see a copy of this document.

At our previous inspection in July 2017 we identified a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured some areas of the premises or equipment that people used was clean. At this inspection we found that sufficient progress had not been made in this area and therefore, the provider continued to be in breach of this Regulation.

On the first day of our inspection there was a strong odour of urine in some areas of the home. One person's crash mat in their room remained unclean during the day and their bed frame was very dusty and their

drinks table had ingrained dirt on it. A sink in another person's room was unclean and the hairbrush in their room was full of hair. A chair in a communal area was unclean underneath the cushion. The medicines trolley where staff prepared people's medicines was unclean. Two communal bathrooms remained unclean during the day.

This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

On the second day of the inspection we found that most of these issues had been resolved and improved upon. However, we still saw that one communal bath was unclean. We alerted the provider to this who agreed it was unacceptable and arranged for the bath to be cleaned immediately.

We found that some staff had not received the appropriate support, training and supervision to enable them to carry out the duties they were employed to perform. This increased the risk of people receiving unsafe or inappropriate care. In the case where staff had implied they were experienced within care at the time of employment, the registered manager and provider had not assured themselves this was the case before allowing them to work unsupervised.

One staff member who had been employed in July 2017 as a deputy manager had worked previously in care. However, the registered manager had not completed sufficient checks of their competency before allowing them to work unsupervised. This staff member had also not received any training that the provider had deemed as being necessary.

Another staff member had been employed by the provider as a night care assistant in August 2017. From the end of October 2017 this carer had been promoted to a senior carer working on nights. This meant they were in charge of that shift. We found that this member of staff had not had any previous experience working within care. They had completed their one day induction training that covered areas such as moving and handling people, fire safety, basic food hygiene, infection control, COSHH (Control of Substances Hazardous to Health) and safeguarding adults. However at the time of our inspection, they had not completed training in a number of other areas such as medicines management. The induction training they had received had been performed by an outside company. When we checked this companies' website, it clearly stated that this training was only suitable as refresher training for staff who had previous experience of working within care. Therefore it was not appropriate for this staff member.

This staff member had only completed three shadow shifts with a senior member of staff before being placed in charge of a night shift. The only recorded check we saw that had been completed in relation to their competency was in respect of medicine administration. The registered manager had completed this on 6 November 2017 where they had deemed the staff member competent to perform this role safely. However, medicine records showed the staff member had administered medicines on 1 and 2 November 2017. This was prior to them having been deemed as being competent or completing their official training which the registered manager told us they did on 28 November 2017. The provider confirmed the staff member should have received training before administering medicines. This practice placed people at risk of receiving unsafe care.

Staff told us of another staff member who was working as a domestic. We checked their training record and saw they had been employed by the provider for over three months. They had not completed all of their induction training including in infection control or COSHH. These two subjects are fundamental training for staff working as domestics. This is so they understand how to clean items effectively to reduce the risk of infection and how to protect themselves and others from exposure to certain substances.

The provider used agency staff to cover shifts their existing staff were unable to work. The registered manager told us they did not check that the agency staff had the appropriate knowledge and skills to keep people safe before allowing them to work within the home. We saw that one agency staff member had not given a person one of their medicines correctly at night when they started working in the home.

This was a new breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

After the inspection visit, the provider told us that one of the staff members discussed above had been observed when providing personal care to people but we saw no records of this within their care file.

We found that most staff used good infection control practices during the inspection. They wore gloves and aprons when providing people with personal care. However, we did see one staff member using poor practice. They were observed to hand people biscuits from a tin and place them either into people's hands or directly onto the table. They did not wear gloves whilst doing this and did not offer people tea plates even though these were available on the tea trolley. Also, when we looked in one communal toilet we found a trolley of unclean laundry was being stored in there which made the toilet and the adjacent area of the home smell unpleasant.

Five of the six people we spoke with told us their requests for assistance from staff were usually met within good time, although they all added they sometimes had to wait. One person told us, "If I need some help then I press the buzzer. They are generally pretty quick but there are times when I have to wait about 15 minutes when they are busy or on the handover." Another person said, "I press the buzzer and I can wait from a few minutes to sometimes 10 depending on the time of day." A further person told us, "If I press my bell they are not bad at turning up, but there are times when you can wait a little while." The relatives told us they thought there were enough staff on duty. One told us, "They are pretty good at responding to my mother's buzzer if she presses it." Another relative said, "They are pretty good and respond to her buzzer."

We received mixed views from the staff about staffing levels. All staff said that when they were fully staffed, they could provide people with care that met their needs. One staff member said they felt there were consistently enough staff available however, the other four told us there were times when the provider's staffing requirements were not being met.

Four staff were asked when they were understaffed, what sort of impact this had on people. They gave us varying views. All but one of them said they felt they could keep people safe and all said that on occasions, people would have to wait for assistance with personal care. Two said they could still ensure that people received vital care such as help with eating and drinking, re-positioning and with continence care. However, two others said they were not always able to help people in these areas when it was required. For example, check people's continence or re-position them every two hours. Were therefore looked at people's records in relation to these areas.

Some people's records we checked supported that people may not have received these checks or been re-positioned as required. For example for one person's records, who staff said should have been re-positioned every two hours during the day, showed that on 25 November 2017 they had only been supported to change position at 6.30am, 4pm, 7.30pm, 10.30pm, 11.30pm and 4.30am. For another person, their continence records showed they had sometimes not been checked for up to seven hours during the day. However when asked, staff gave us mixed views as to whether they felt the records were an accurate reflection of the care people had received. Some told us they thought they were but others said that the records were not accurate. This was they said, because they were aware that some staff forgot to update people's records and that agency staff did not always complete them. Therefore, we could not be sure they were an accurate

reflection of the care people had received.

On the first day of the inspection, the home had been short of one staff member from 7am to 9am due to a staff member calling in sick. From 9am the deputy manager assisted staff on the floor. For the majority of the inspection, we saw that staff answered people's requests for support in a timely manner. There were occasions that communal areas were not being monitored but staff often walked through these to ensure people were safe. However, we saw that in the morning staff did not have time to spend with people and they were only able to interact with people when they were performing a task. We observed that some people had to wait for assistance with their breakfast and had not received a wash until late morning. Staff gave us mixed views on this with some saying it had been people's choice and others saying they had to wait due to the shortage of staff in the morning. The people were not able to tell us whether it had been their choice to get up late morning and their preferences had not always been recorded within their care records.

The provider told us they used a tool to calculate the required staffing numbers based on people's needs. This had calculated that the number of staff needed on each shift including a senior member was six in the morning, five in the afternoon and three at night. We checked the staff rotas for October and November 2017 to see if these numbers had been consistently met.

We found in October 2017 that on only three of the 23 days checked, the required staffing numbers had been met for the whole day. On seven occasions there had been one staff member less working in the morning and on four occasions, two less. In the afternoon, the home had been one staff member short on eight occasions. In November 2017, on 14 of the 26 days we checked a full complement of staff had been working on each shift. On the remaining 12 days, the provider's assessment of safe staffing levels was not adhered to. We noted that on 18 days in October 2017, at least one staff member had not worked either part of their shift or a full shift due to sickness and that this had reduced to 13 days in November 2017.

We spoke with the provider about this and discussed the sickness levels the home had experienced. They said they had been working to address this. The provider said that in response to unplanned absence, existing staff would be asked to cover and that the registered manager and deputy manager would also help. Agency staff were also being used regularly to cover shifts. Three new staff had recently been appointed and the provider told us they were limiting the number of people being admitted into the home until they were confident a more stable staff team was in place.

Therefore, we have concluded that the staffing levels assessed as being required by the provider were not always being met. However, the main reason for this was due to staff sickness which the provider was actively trying to manage. Efforts were made to cover any unplanned staff absence where this occurred. Further improvements are required to ensure that the number of staff deemed as being required by the provider is consistently met.

We looked at four staff recruitment files to ensure staff had been recruited only after the required checks had taken place. All staff had been subject to a Disclosure and Barring Service check to ensure they were suitable to work in a care setting. Photographic identification had also been taken and references obtained from previous employers where appropriate to check staff conduct in their last role. However, we found gaps in employment for one member of staff and that a full employment history had not been gathered for another as is required. The reasons for these gaps had not been recorded within the staff member's recruitment files although the registered manager said they had explored them and told us why these had occurred. Satisfactory responses were given.

One staff member had no evidence of a qualification within their file which they said they had. The

registered manager told us the staff member had recently left and had taken the certificate with them. However, the provider said a copy should have been retained within the file. We were therefore satisfied that the appropriate checks had been made but have judged that improvements are required in that any anomalies found during the recruitment process, must be recorded in staff files.

All of the people we spoke with told us they felt safe living in The Laurels. One person said, "Yes I do feel safe here, particularly down my corridor." Another person said, "I do feel safe here." A further person told us, "I definitely feel safe here." All of the relatives we spoke with agreed. One said, "My mother is absolutely safe here and they telephone if she is not well to keep me updated." Another relative told us, "I think she is safe here."

The staff we spoke with about safeguarding people from the risk of abuse all demonstrated they understood this subject. They could tell us the different types of abuse that people could experience. They all said they would report any concerns to a senior member of staff or outside of the home if they felt this was necessary. All staff identified either CQC or the local authority as appropriate organisations they could report such concerns to.

All of the staff told us that if people had unexplained bruising, they would report this also to a senior member of staff. The care records we looked at demonstrated the registered manager had taken action and investigated any concerns raised of this nature. If any action had been required, such as a review of people's medicines we saw this had been taken. However, the registered manager had not ensured that agency staff had the relevant training in this area so could not be assured that they would report any concerns if needed.

All of the staff we spoke with demonstrated they knew what action to take in an emergency situation. Some staff were able to describe what action they had taken in respect of a recent fire that had occurred within the home to keep people safe. The provider told us the fire service had praised the staff for their quick thinking and safety measures they had taken during this emergency.

The provider had assessed risks in relation to legionella and these were managed well. A qualified engineer had serviced lifting equipment in line with the relevant legislation to ensure it was safe to use. The mains gas into the home had been checked and a safety certificate issued by an engineer.

Inadequate

Is the service well-led?

Our findings

At our last inspection in July 2017 we rated Well Led as Requires Improvement. At this inspection, the leadership and management of the service had declined. Therefore we have rated Well Led as Inadequate.

At our previous inspection in July 2017 we identified a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have effective systems in place to assess and monitor the quality of care being provided to people. After that inspection, the provider wrote to us and said they would be meeting the three breaches of legal regulations by 10 October 2017. At this inspection we found that this was not the case and that sufficient progress had not been made in this area and therefore, the provider continued to be in breach of this Regulation.

In their action plan they sent us after the last inspection, the provider told us that all exposed pipework within the home had been covered but we found this was not the case. This was the third inspection in a row that we had found this issue. The provider told us they had taken advice from a local plumbing company who had stated that exposed pipework of a certain length was not a risk to people's safety. However, after discussion with the provider they agreed the exposed pipework we found was a risk to people if they fell against it. The provider said they were aware of the Health and Safety Executives guidance on protecting people from the risks of hot water and surfaces (published in 2012) but had not implemented this guidance. The failure to robustly assess this risk and take action had placed people at risk of unnecessary harm.

Also in their action plan, the provider had said that all toiletries were securely locked away but we found this was not the case. When we spoke with the registered manager about this, they told us they thought toiletries referred to items such as razors or steradent tablets. They had therefore not assessed whether it was safe to leave such items unsecure.

It had been stated in the action plan that a daily management walkabout had been put in place to monitor the cleanliness of the home and equipment that people used. However, we again found issues within this area. The action plan stated that a daily task sheet was in place in relation to the cleaning of equipment and communal areas. For one bathroom that remained unclean over both days of the inspection visit, this task sheet was blank and had not been completed. This had not been identified as an issue during the daily management walkabout which was therefore not effective.

We were also advised that a robust daily monitoring system had been put in place to highlight any issues and risks associated with people receiving safe care and treatment. However, when we looked at people's care records we found gaps or potential issues that had not been identified or investigated. For example, some people's records showed there were large gaps between the times they were being assisted to be re-positioned or had continence checks. These had not been identified or questioned by the registered manager or provider.

Since our last inspection, a system had been introduced for staff to check that people's pressure mattresses were set at a correct level to ensure they were effective. However, for the one person whose records we

checked, we saw there were gaps in these records for 21 days of October 2017. This demonstrated that the provider's daily monitoring system was not effective at identifying and mitigating risk to people's safety.

Gaps in people's medicines records had not been identified or explored to ensure people had received their medicines correctly. We found numerous gaps in these records for November 2017. Stock levels of medicines were not always being recorded and therefore, the provider had no means of monitoring effectively if people had received their medicines correctly.

There was no effective system in place to ensure that people's care records were accurate or that they reflected the current care that people required. This is important to help reduce the risk of people receiving unsafe and inappropriate care.

At our last inspection, we had identified an issue in relation to how the provider monitored staff competence. In response to this finding, the provider told us in their action plan that a new system was to be put in place to assess and monitor staff practice. This was to include 'on the floor' supervisions and observations. However at this inspection visit, we again witnessed some poor staff practice. Records also demonstrated that some staff were moving people following a fall when they had said they were in pain and were not contacting paramedics. This was in direct contravention of the provider's falls policy which specifically states, 'If the individual is complaining of pain then paramedics should be called and the individual much not be moved.'

When we looked at the records of staff competency checks we found that these had not all been completed to ensure staff were competent to perform their roles in all areas. The registered manager told us they were also not checking that agency staff had the relevant skills to provide people with safe and appropriate care. Furthermore, not all staff had received appropriate training to perform their role before they started to perform care tasks unsupervised. The provider told us they were not aware this had occurred and the registered manager could not offer an explanation as to why this had happened. The provider's system to monitor that staff had received appropriate training and were competent to perform their role was therefore not effective.

The provider had employed an external consultant who had completed a 'mock' inspection of the home on 2 November 2017. The provider confirmed this was received on 3rd November 2017. The consultant had identified that some people did not have their call bells within their reach and said this needed to be addressed. They had also found that pressure care risk assessments had not been reviewed regularly. We found the same issues during our inspection some 25 days later. This demonstrates that timely and appropriate action had not been taken to correct these issues.

The provider and registered manager had not ensured that all staff working in the home had been made aware of the risks associated with a person smoking. This had resulted in one staff member not following the required control measures when assisting a person to smoke. The person had accidentally got hold of a lighter and started a fire in the home. This failure in communication had placed people at serious risk of harm.

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

During this inspection visit, we became aware of two incidents that we had not been notified about as required by law. These were both in respect of serious injuries two people had experienced. One was in respect of a cut to the head following a fall and the other a significant pressure sore a person had

experienced.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager analysed incidents and accidents each month to help them identify if any actions needed to be taken to reduce the risk of them re-occurring. Where action was needed, such as a referral for specialist advice we saw this had taken place. However, during this inspection we found that two incidents had not been brought to the attention of the registered manager. Therefore, their analysis may not have given a full picture to enable appropriate actions to have been taken. For example, one person had experienced three rather than two falls in November 2017. The registered manager was only aware of two and had therefore not referred the person for specialist advice.

Most of the people we spoke with told us they were happy living in The Laurels and felt there was an open culture where they could raise concerns without fear. After the inspection visit, a relative contacted the service. This was shared with us and showed they expressed they were happy with the care their family member had received and how the home was managed. In relation to the management of the home another person told us, "I am still happy here. I find the staff approachable. I think the home is managed well." Another person said, "I am happy here." However two other people were not so positive. One person told us, "I am generally happy here but the home could be managed a bit better. Last weekend there was confusion with who was going to be in charge." A further person said, "I'm not happy here. I would rather be at home. I can't fault the staff. I sometimes see the manager but not very often unless she wants something."

All of the staff we spoke with told us the senior staff including the registered manager were approachable and open. They felt they could raise concerns and that these would be listed to and dealt with. However, staff gave us mixed views about whether they felt the home was managed well and the availability of the registered manager. Some said it was well led but others said they felt the home was not run well. Staff also gave us a mixed picture of the registered manager's presence on the floor. Some said the registered manager was often available to assist and help then when needed but others said they rarely saw the manager during their shift.

After the inspection visit, the registered manager told us they walked around the home on their arrival in the home. They said that here, they greeted all residents and staff and asked if there were any concerns. They said they had an open door policy where they could be accessed at any time. They also said they were always available on the end of the phone and happy to go into the home when needed if they were not working that day.

We also received mixed feedback from staff in relation to their morale. Some described it as good but others said it was up and down and that they were often stressed and felt undervalued. Some staff felt they were not appreciated for the work they did and said they did not often receive a thank you. Improvements are therefore required to ensure that people and staff consistently feel that the there is a positive culture in the home that is open, inclusive and empowering.