Defiant Enterprises Limited

The Laurels Care Home

Inspection report

The Laurels
West Carr Road
Attleborough
Norfolk
NR17 1AA

Tel: 01953455427
Website: www.thelaurelscarehome.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 10 and 13 January 2017 and was unannounced.

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.' At the time of our visit, there were 41 people living in the home, the majority of who were living with dementia.

There was a manager registered with the Care Quality Commission (CQC) as is required. 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 and associated Regulations about how the home is run. Following our inspection in September 2016, the registered manager stepped down from their post within the home but did not de-register with the CQC. The head of care took over the running of the home as the manager but they subsequently left their employment in December 2016. The previous registered manager who was working as the deputy manager in the interim resumed managing the home. At this inspection, a director of the provider (who will be referred to in the report as 'the provider'), told us this arrangement was temporary until a new manager started on 16 January 2017.

At our last inspection on 28 September 2016 which had been a focussed inspection in response to concerns we had received, we asked the provider to take action to make improvements in respect of the quality of care that was provided to people. At this inspection, we found that the necessary improvements had not all been made. This resulted in six breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we have told the provider to take at the back of the report.

There were not enough staff working in the home to keep people safe and to meet their preferences. This also impacted on people receiving adequate stimulation to enhance their wellbeing and reducing the risk of them experiencing abuse. In most cases, risks to people's individual safety had been assessed but actions had not always been taken to mitigate these risks. Some people had therefore experienced poor care or had been put at risk of harm.

Some areas of the home and equipment people used were unclean and not all risks in relation to the safety of the premises had been assessed.

People's medicines had not all been managed well and people continued to be inadequately supported to eat and drink enough to meet their individual needs. Some staff had received adequate training to perform their roles however, others had not which placed people at risk of receiving poor care. Some staff demonstrated poor care practice which placed people at risk of infections. There was a lack of evidence to support that staff care practice was regularly assessed and monitored to ensure they were competent at

their role.

There continued to be a lack of effective governance and leadership in place to assess, monitor and mitigate risks in relation to people receiving poor quality care.

People were supported with their healthcare needs but staff did not always follow the advice of healthcare professionals. When people raised concerns, these had not always been taken seriously or investigated appropriately. Some people's dignity and privacy was not upheld.

Staff sought consent from people in line with the relevant legislation and the necessary checks had been made before staff started working in the home to ensure they were eligible to work within a care setting. People and their relatives were involved in making decisions about their care as much as they wished to be.

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.

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.

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.

Risks to people's safety had not always been assessed. Where it had been, actions had not always been taken to mitigate these risks.

There were not enough staff to keep people safe and to meet their needs or to protect them from the risk of abuse.

People's medicines had not been managed well and the risk of the spread of infection was not being managed effectively.

Potential risks to people's safety from the premises had not all been assessed.

The required checks on staff before they started working in the home had been completed.

Is the service effective?

Inadequate

The service was not effective.

Not all staff had received enough training to enable them to provide people with effective care.

People did not always receive enough to eat and drink to meet their needs.

People were supported with their healthcare needs however, staff did not always follow the advice of healthcare professionals.

Staff sought consent in line with the necessary legislation.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most staff were kind and compassionate but some people's dignity and privacy was not always upheld.

People and their relatives were involved in making decisions

about their care.

Is the service responsive?

Inadequate

The service was not responsive.

Staff did not always have time to interact with people in a meaningful way and were not always responsive to their needs.

People's care needs had been assessed but their care records did not always contain enough information to guide staff on the care they required. Some did not provide an accurate reflection of the care required to meet people's individual needs.

People and their relative's complaints had not always been dealt with appropriately. Some people felt unable to raise complaints.

Is the service well-led?

Inadequate

The service was not well led.

Since our last inspection, adequate improvements had not been made to the quality of care people received.

Not all of the systems in place to assess and monitor the quality of care provided were effective.

The leadership within the home was inadequate. Some staff and people felt unable to raise concerns demonstrating that there was not an open culture.

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 home under the Care Act 2014.

This inspection took place on 10 and 13 January 2017. 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, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We reviewed other information that we held about the home. 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. We reviewed the notifications the provider had sent us. We also obtained feedback from the local authority quality assurance and safeguarding teams, the local clinical commissioning group and various healthcare professionals prior to and during the conduction of the inspection.

During the inspection visit we spoke with six people living at the home and three visiting relatives in detail. We spoke to four other people briefly about the care they received. We spoke with seven staff which included care, domestic, kitchen and activities staff. We also spoke with the registered manager, the provider and one visiting healthcare professional. We spoke with two other healthcare professionals during the conduction of the inspection.

The records we looked at included 10 people's care records, people's medicine records and other records relating to people's care, three staff recruitment files and staff training records. We also looked at records relating to how the provider monitored the quality of the service. We observed how care was provided to people during the inspection visit.

After the inspection visit we asked the registered manager to send us some further information in relation to

people's care and staff training. This was received promptly.

Inadequate

Is the service safe?

Our findings

At our focused inspection in September 2016, we found that the provider had not always assessed risks to people's individual safety and that where they had, actions had not always been taken to mitigate the risks. This resulted in a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan that detailed the improvements they planned to make. They told us these improvements would be made by November 2016. At this inspection, we found that the necessary improvements had not been made and that the provider remained in breach of this regulation. Actions had not always been taken to prevent the risk of people experiencing harm.

It was recorded in one person's care record that they were at high risk of choking. A healthcare professional had therefore advised that the person was required to receive a pureed diet and to have their drinks thickened to help mitigate this risk. The registered manager confirmed that this was the case. However, during the first day of the inspection we saw this person trying to eat a piece of toast. On another occasion, a staff member gave them crisps to eat and a drink that had not been thickened. This placed the person at serious risk of harm. The person was also assisted regularly to drink from a spouted beaker but again this was against the advice of the healthcare professional. From the person's records we saw that they had been receiving on occasions, a soft rather than pureed diet which could place them at risk. We told the registered manager of our observations who put immediate actions in place to prevent this from re-occurring.

This person had been assessed as being at moderate risk of falls. We observed that a crash mat was by their bed. However, a healthcare professional told us that during a recent visit, they had asked that the crash mat be removed. This was because the person could move themselves from their chair to the bed and having a crash mat in place was a potential trip hazard. Having this still in place increased their risk of them having a fall.

Another person had been admitted into the home for respite care eight days prior to the first day of our inspection visit. The initial assessment of their needs identified that they had tripped and fallen previously whilst living in their own home. Therefore they were at risk of falls. No risk assessment had been completed in respect of this risk and there was no information for staff within the person's care record to guide them on how to protect them from the risk of falling. They had fallen twice since moving into the home. One of these falls had resulted in the person banging their head that had required medical attention. A risk assessment had only been put in place after the second fall had occurred. It had been recorded within this person's care record that they required a stick to walk. We observed this person within a communal area but their stick was not near them. Therefore, if they tried to walk they would not have the necessary equipment near them to help them walk safely.

We observed one person walking around the home. They looked unsteady and had to grab hold of the hand rails whilst walking. We also saw them walking in their room. This person's care record stated that they were at high risk of falls and to reduce this risk, staff were to encourage them to use their frame. However, their frame was not in their room and there were no staff available to encourage the person to use it when they were walking within the communal area, placing them at risk of falls.

Prior to the inspection, we had received a concern that the staff were not identifying when people were at risk of developing pressure ulcers so that mitigating actions could be taken to try to reduce the risk. In response to this concern, we had written to the manager and asked them what actions they had taken to improve this. They told us that records were in place to check people's skin integrity each day and that these were monitored and acted on regularly. However, we found a number of these records were blank and had not been completed to provide assurance that the necessary checks had been made.

One person had been assessed on 25 October 2016 as being at very high risk of developing a pressure ulcer. On 29 October 2016, they developed a pressure ulcer however, the risk in relation to this and the actions required to reduce this risk had not been reviewed. On 28 December 2016, the staff requested a healthcare professional visit the person who had a tissue injury on their heel. A wedge was ordered by the district nurse to help relieve the pressure on the heel. This was received in the home on 30 December 2016. However, healthcare professional records confirmed that during a subsequent visit made by them on 4 January 2017, they found this piece of equipment was not being used and that the tissue damage to the person's heel had deteriorated. On the day of our inspection, the equipment was being used.

It was noted in another person's care records that they had been assessed as being at high risk of developing a pressure ulcer. Two of the actions required to mitigate this risk were for staff to regularly provide personal care checks and to report any concerns to senior staff or the registered manager. However, the records in relation to this person's care indicated that the required personal care checks not always taken place. It had been recorded that on a number of days that this person had been 'independent' with personal care. However, two staff told us the person required assistance with personal care and this was what was stated within the person's care record. On 24 December 2016 it was noted that an area of the person's body was red but the risk in relation to this had not been re-assessed to ensure all appropriate actions were being taken to reduce this risk. When an issue had been discovered in relation to the integrity of their skin, this had been referred to senior member of staff but no action had been taken as the provider required. This issue was reported to the registered manager by another staff member the following day who then took steps to seek assistance from the relevant healthcare professional. This person was found to have developed a serious injury to their skin.

During our walk around the home, we noticed that there were some exposed pipes within a communal area and some within people's rooms. These pipes were very hot to the touch and therefore posed a risk of burns should a person fall against them or in relation to the pipes in the communal area, grab hold of them. We spoke to the provider about this who told us they had not identified this as an issue. We asked them to risk assess the whole building and to put in place any relevant mitigating actions to ensure it was safe in relation to the risk of people burning themselves.

When we walked into a communal lounge, we found that the door handle had been removed from the door. The senior carer told this was because a lock was being fitted on it. However, several nails from the fitting of the door lock had been left on a chair. People living with dementia were observed to walk into the lounge and therefore, the nails were a potential risk to their safety if they did not understand what they were.

All of the people we spoke with told us they received their medicines when they needed them. They also said they had regular access to pain medication if they required it and we observed this to be the case during our inspection visit. One of the relatives we spoke with about the management of their family member's medicines agreed with this. However, we found that the medicine administration records (MAR) did not support that people always received their medicines as prescribed.

We found numerous gaps in the MAR that indicated people may not have received their medicines. We

therefore checked some of these medicines and although some reconciled with the MAR, we found that two people's medicines had numerical discrepancies. These were both in respect of pain killers and showed that there were two more tablets available than there should have been. This suggested that these two people had not received these medicines as they should have done. The senior staff member told us that staff sometimes forgot to update the records and were therefore permitted to update them retrospectively if they could recall they had given the medicine. This is poor practice as it increases the risk of incorrect recording.

Whilst we were speaking with one person in their room, we found a tablet on the floor. We passed this to the registered manager for investigation. They told us that this person required full assistance with their medicines and that the staff member had placed it in a pot for the person. However, the staff member had not witnessed them taking the tablet. This was required to ensure that this person received their medicines as intended by the person who prescribed them.

Medicines were not always kept secure. On one occasion we saw that the keys had been left in the medicine trolley and on another, a packet of one person's prescribed antibiotics had been left on top of it. On both occasions the trolley had been left unattended. Therefore there was a risk the medicines could have been tampered with, removed or inappropriately used by people who did not understand what they were.

The risk of the spread of infection was not being managed well. Some areas of the home had an unpleasant odour and some carpets and furniture within communal areas were unclean. We checked under four of the cushions of two two-seater sofas in one lounge area and found old ingrained food under two of them. This was still there on the second day of our inspection. In one of the communal toilets, an unclean wet flannel was sitting on top of the radiator. A toilet in a communal bathroom remained unclean for the duration of the first day of our inspection visit. The bath had not been cleaned after it had been used. The base of the bath hoist was rusty which meant it would be difficult to clean effectively. An unclean wet towel was left on the floor in a bathroom and a wet flannel on the side of the bath after a member of care staff had supported someone to have a bath. Some people's sinks within their rooms were found to be unclean as were two crash mats that had been placed on the floor near people to protect them from injury should they fall out of bed.

One staff member and the registered manager were observed to use poor practice in relation to infection control. One staff member handled unclean towels without wearing gloves and went into another person's room to speak to them wearing the same apron they had worn when giving another person personal care. The registered manager supported a person with personal care without wearing a protective apron. Other staff were seen wearing nail varnish and having long nails that can make it difficult to clean hands effectively. One staff member was observed cutting up bananas in their hand that was part of the lunchtime dessert and giving them to different people without wearing gloves or washing their hands when moving between people.

The registered manager told us that two domestic staff worked on two days of the week and one on five days. They were responsible for cleaning people's bedrooms, the communal areas and some people's equipment. We concluded that one domestic member of staff was not sufficient to keep the home and equipment people used clean and hygienic.

The evidence above demonstrated that this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Four of the six people we spoke with about safety told us they felt safe living in The Laurels. One person told us, "I've always felt safe here." Another person said, "I feel safe, that's a big thing." However, two people said

they did not feel safe. One person said, "I've been happy here, but I don't feel safe now." They said they felt this way as they had been told by the staff that they upset everyone. Another person said that they felt unsafe at night because some people entered into their room. They added that they now had a key so they could lock their door to prevent this from happening. They told us, "It's frightening waking up and seeing them in my room. I lock myself in at night."

Two of the three relatives told us they did not feel their family member was safe. One relative said, "It's changed a lot since [family member] has been here. There are more people with dementia and you can't stop them coming into [family member's] room. They shout a lot and it's upsetting [family member]." Another relative told us they felt that staff were unable to ensure their wife's safety as other people who lived in the home 'trespass and come into [family member's] room.' They added, "They take [family member's] clothes and I don't know what else they do."

We spoke with three staff about safeguarding people from the risk of abuse. Two of them understood what the different types of abuse were and what action to take if they were concerned someone was being abused. However, one staff told us they would not know what to do or what to look out for. We saw that two other staff who worked on night shifts had not received training in safeguarding which meant they may also not of understood how to recognise potential abuse or how to report it.

During the inspection visit, we saw two people were regularly being verbally abused by other people living in the home. One person who had a cold and was coughing was regularly told they were 'useless, dirty, disgusting and horrible' by one person and told to 'shut up' on several occasions by another. Another person who was regularly calling out was told numerous times to 'shut up' and 'be quiet' by other people. Staff were not always present when this happened but when they were, they did not take any steps to prevent the abuse from continuing to happen such as engaging people in an activity or distracting them. We also saw that three people were regularly shouting and swearing at each other in the communal lounge when no staff were present.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At our previous two inspections in December 2014 and May 2016, we had told the provider that they needed to improve their staffing levels to ensure they could meet people's needs. However, we found during this inspection, that sufficient numbers of suitably qualified, competent, skilled and experienced staff had not been deployed effectively to meet people's care needs.

Five of the six people we spoke with about staffing levels within the home told us they felt there were not enough of them to support them when they required this. One person told us, "There are not enough people around. They are losing a lot of staff. I don't know why, but there is not enough staff to cope." They added that there was often a delay in replying to their call bell, or that staff would come in and switch it off, but forget to come back. Another person said, "There are not enough staff to do everything. They don't have time to sit and talk." A further person told us they needed help with personal care, but had to wait until staff had time to support them.

All of the relatives we spoke with also said they felt there were not enough staff working in the home but said they were usually cheerful and appreciated that they were doing their best. One relative told us, "There seems to be a high turnover of staff at the moment and there's not enough to get [family member] up." Another relative said, "They're short of staff. I see different ones each day."

All of the four staff we spoke with about staffing levels told us they felt there was sometimes a lack of staff

which they felt made people unsafe. They said they were not always able to reduce the risk of people falling as there were not enough of them to monitor people effectively. Two staff when asked, also said they did not have time to provide people with adequate personal care. Three staff told us that they had recently found people wet or unclean in their rooms. They gave us mixed views as to whether they were able to support people with eating, drinking and re-positioning when this was required. They all told us that they regularly worked with less staff than had been stipulated as being required by the provider.

Our observations confirmed that staff were not effectively deployed to meet people's needs in a timely manner or to keep them safe. One person was heard shouting for help but there were no staff within the area to assist them. They told us they wanted to move from their chair into their bed as they were uncomfortable in the chair. We had to find a senior member of staff who then supported the person to move. On the second day of the inspection visit, we again heard this person shouting out for help. When we saw them, they were visibly distressed and crying and asking to go back to bed. Again there were no staff visible and we had to request the registered manager, who was covering for an absent staff member until the necessary cover could be provided, to help this person back to bed.

In the late afternoon on the first day of our inspection, we saw that two of the four care staff were taking tea trolleys around the home and that the senior was doing the medication round. This left two staff and the registered manager to monitor the three lounges and two dining rooms and to provide people with support with personal care if this was required. Whilst we were walking around the home, one person who was in the dining room told us they were desperate for the toilet. They had no means to alert the staff other than to shout out for help. There were no staff available so we had to ask the registered manager to provide assistance. Another person was observed confused and distressed within a corridor. They told us they were looking for the bathroom as they wanted to wash their hands. There were no staff available to help them with this.

Throughout the inspection there were times when there were no staff available to monitor communal areas within the home. Some people were visibly becoming upset but there were a lack of staff available to diffuse these situations. Staff were not available to ensure that people who required their frames near them to mitigate the risk of them falling had them within their reach.

We checked the staff rotas from 12 December 2016 to 1 January 2017. We found that on ten of the 21 days the staffing numbers were below those stipulated as required by the provider. On the first day of our inspection, two senior staff had been working in the morning. During this time, they both assisted with the medication round and we were advised by a senior member of staff that one of them had come into work to update care records. However, one of them had been included in the number of care staff that the provider had deemed were required to provide people with safe care. This meant that in the morning, there were effectively four care staff rather than five available to provide people with support.

We spoke with the registered manager and the provider about how they calculated the number of staff required to meet people's needs. They told us this was worked out based on a ratio of staff to people. Therefore, the number of staff required was not based on people's individual needs. The registered manager confirmed that their calculation did not take into account staff having to complete other tasks such as taking the tea trolley around the premises in the early evening.

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

The provider told us they were using agency staff to cover any staff shortages. They said that on occasions it was difficult to cover staff shifts when staff called in sick at the last minute. They also said that sometimes

the agency staff did not turn up. They confirmed they had recently recruited five new staff to work in the home and were advertising for two others. A further member of the domestic team was also to be recruited.

There was written guidance in place to support staff with the administration of people's medicines. This included a photograph of the person so they could ensure they were supporting the correct person and information on how and when to give people PRN (as and when) medicines.

The required checks had been completed when recruiting new staff to the home. These included checking with the Disclosure and Barring Service that the staff member was deemed safe to work with people living in the home and obtaining references about the staff member's character.

In relation to fire safety, we saw that the fire exits were kept clear and that regular checks on the fire system within the home had been completed as had checks on the electrics and gas systems. Checks for legionella had also taken place and equipment used to support people to move had been serviced in line with the relevant legislation to ensure it was safe to move.

Following advice from a healthcare professional, the provider had checked people's frames and had contacted the necessary organisation to replace any that were damaged or that required repair.

Inadequate

Is the service effective?

Our findings

At our last inspection in September 2016, we found that people had not always received enough to eat and drink to meet their individual needs. This resulted in a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan that detailed the improvements they planned to make. They told us these improvements would be made by November 2016. At this inspection, we found that the required improvements had not made and that the provider remained in breach of this regulation. During the inspection we received a concern from a healthcare professional that risks to people in respect of malnutrition and dehydration were not being managed effectively.

People's risk of not eating enough had been assessed and we saw that this had been completed regularly. Where they were at risk, actions needed to mitigate this risk had been recorded within their care records. We saw that some actions had been taken. For example, these people had been weighed regularly to monitor whether they were losing weight and the chef confirmed they were fortifying these people's foods with extra calories. However, not all actions as recorded within these care records to mitigate this risk had been taken.

For example, the records for two people who were of a low weight, said they required a high protein diet. When we spoke to the chef they were not aware this was required and the records did not support that these people received this type of specific diet. We saw that one of these people had received some milky drinks or milkshakes. However, this had not been on a consistent basis with it being recorded that they had only been offered these types of drinks on eight occasions over a 21 day period. The other person had only been offered these types of drinks on four occasions within this time. No snacks had been recorded as being given to either people to boost their calorific intake. One person had lost four percent of their bodyweight since September 2016 and records indicated the other person had also lost some weight.

Another person whose care we looked at had lost 9% of their bodyweight since October 2016. It had been noted in their care record by a healthcare professional that overall, they had lost 18.8% of their bodyweight. It was recorded in their care record that they needed to receive a high calorie diet and be offered snacks regularly such as crisps and sandwiches and milky drinks to help them put on weight. The records we viewed did not support that snacks or milky drinks had been offered to this person. The person's records showed that in December 2016, the staff had needed to be prompted by a healthcare professional to refer this person to the GP for a dietician referral due to their weight loss.

According to the care record of another person who was of low weight, they required regular snacks. The records in relation to their food intake did not support that they were being offered snacks regularly to boost their calorific intake. The records also indicated that this person often went between 16 and 17 hours without being offered any food. In the morning, they were offered some scrambled egg but we saw they did not eat any. However, their food record for the day stated they had eaten all of it. During our observations over lunchtime, we saw this person ate all of their lunchtime meal but they were not offered a second portion. It was recorded that they had received some milky drinks and milkshakes to increase their caloric intake but this had been inconsistently applied. Their fluid records over a 21 day period, showed they had been offered them only on 12 occasions over this period.

We asked the chef what types of snacks were available to people. They told us and we observed that snacks such as cake, crisps and biscuits were offered to people. We asked them if healthy snacks such as fruit were prepared. They told us that people had fruit in their own rooms so they did not prepare any fruit for people.

Since our last inspection in September 2016 a new system had been put in place with the aim of increasing people's calorific intake. This was called the 'red tray protocol'. People who were at risk of not eating enough received their food on a red tray. If this was returned to the kitchen with uneaten food on it, the chef would alert a senior member of the team so they could offer an alternative to the person. We asked the chef how this system was working. They told us that on occasions it worked well. However they told us that staff would sometimes pile a number of plates onto each tray which then made it impossible for them to ascertain who had eaten what. They also told us there was no mechanism in place to record when people had received their meal so they could make sure people had been offered one.

The records we viewed did not support that when a person had not eaten much of their food that an alternative was always provided. We also saw that when staff were not present within the dining area, one person who was on the red tray protocol started to give their food to another person. Therefore, when their plate was returned to the kitchen it would not have given an accurate reflection of what food they had eaten.

Where people were at risk of not drinking enough, actions for staff to follow to help mitigate this risk had been recorded in their care record. In most cases, a target fluid amount was in place. Although this target was higher than we found at our last inspection in October 2016 it was again a generic figure, this time of 1200mls for each person. This had not been assessed based on the person's individual need. The provider told us during a meeting in October 2016 that we held with them, that they had received some advice from the local clinical commissioning group regarding target fluid intake for people. They had handed us a copy of that document which clearly stated that an ideal intake over a 24 hour period for people was 1500mls. However, this target had not been applied.

During the inspection we saw that people in communal areas had drinks near them that they could help themselves to and we did see staff supporting them to drink. However, for one person whose care we looked we saw their drink had been placed out of their reach within their room. It was stated in their care record that they could sometimes drink independently but that on other occasions, they needed prompting. We noticed another person also had their drink out of reach. They told us they could drink independently so there was no reason for it to be out of their reach.

Records did not show that people who required support to drink their fluids were receiving this regularly. One person's fluid intake records indicated that on 23 December 2016 they had not been offered a drink for over six hours during the day and that they did not have any fluid after 3pm on 26 December 2016. For another person, the records on 30 December 2016 indicated no drink had been offered for nearly four hours and that no drinks had been offered after 5pm on 29 December 2016. It was recorded in another person's hydration support plan that they required support to have a drink every two hours. However, their fluid records consistently showed this was not being done. The target fluid intake for these people had not been recorded on the fluid chart to provide staff with guidance.

The records for these two people also showed that on occasions, when the person had not reached their target fluid intake for the day, the frequency of offering drinks the following day had been increased which had resulted in an increased fluid intake. However, this had not been consistently applied. For example, one person had been recorded as only drinking 820mls of fluid on 25 December 2016 (380mls under target) having been given assistance on six occasions by the staff. On the following day they had again only been

given assistance on six occasions resulting in a consumption of 530mls (670mls under target). For the other person, on 25 December 2016 it was recorded they had been supported with fluids on nine occasions and had drank 900mls. However, on 26 December 2016 the staff had only supported them five times resulting in an intake of 450mls. This demonstrated that there was no consistent approach being taken to ensure these people received enough fluid to meet their needs.

During our inspection, we became aware that one person had recently been diagnosed as being clinically dehydrated. We therefore looked at their fluid intake records from 23 December to 12 January 2017. During this time the person had never reached their target fluid intake. We found again that when the person's fluid intake was low that action had not always been taken to increase their fluid intake. For example, on 23 December 2016 their total intake was recorded as 800mls but they were only offered fluid on six occasions the following day which resulted in an intake of 450mls.The following day they were again only offered fluids on six occasions having an intake of 420mls.

We received mixed feedback from the staff about whether they were able to provide people with sufficient encouragement to eat and drink enough to meet their individual needs. One staff member said this was not a problem but two others told us that they did not always have time to do this. The registered manager told us that staff had received training in relation to meeting people nutritional and hydration needs recently and the staff told us this was the case. However, we remained concerned about how the provider ensured people received enough to eat and drink to meet their needs.

This resulted in a continual breach or Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Most of the comments we received from people about the food was positive. People told us they had a choice of food and that alternatives would be made for them if they didn't like what was on the menu. One person told us, "The food is good, there is a range of choices or I can opt for something else if there is nothing I fancy." We saw this person had a selection of drinks on their bedside table. Another person said, "The food is brilliant. The cook comes in and tells us what's on, or will offer us something else if there is nothing we like." However, one person said that they felt the food and the menu was 'strange' and a relative said they visited each day at lunchtime to assist their family member with a meal. They told us, "The girls are so busy, I make sure [Family member] has something to eat."

We observed the lunchtime meal in both dining rooms. We found this to be a variable experience for people. People were offered a choice of food and drink and staff were present to ensure people received the support they required. However, in one dining room one person became upset and distressed but the staff did not attempt to diffuse the situation. In the other dining room, one person received their meal before everyone else on the table. They were assisted to eat their meal and after this, everyone else on the table received their meal. This may have been uncomfortable for people if they had to watch one person eating their meal if they were hungry and also for the person who was eating their food in isolation. Further improvements to the dining experience for people are therefore required.

Not all staff had received appropriate support, training and supervision to enable them to carry out the duties they were employed to perform. We requested a copy of the staff training matrix. The registered manager told us that this document was accurate and reflected the training staff had completed. This detailed that nine of the 16 care staff who had worked in the home for more than three months at the time of our inspection had not completed any training in basic food hygiene. The registered manager told us this was mandatory training that should have been completed. We also saw that five of these staff had not completed basic infection control training. We had observed some staff within the home, including the

registered manager who told us they had provided staff with training in this area, demonstrating poor infection control practice.

Whilst looking at some people's personal care records, we found that some staff who had provided people with personal care whilst working in pairs, had not received any training in infection control. One staff member we spoke with who had worked in the home since September 2016 worked as the chef and also as a member of the night care team. They told us they had been working some night shifts where they had been included as one of the three care staff as deemed required by the provider. However, the training matrix showed that they had not completed any training at all in relation to care duties. They had also not attended any training in food hygiene and food safety although their primary role was that of a chef. They confirmed they had not received any training as did the registered manager. On 25 December 2016, records showed that none of the staff on night duty had received training in how to administer first aid placing people potentially at risk.

Although a number of people living in the home were living with dementia, eight staff who had worked in the home over three months had not completed any training in relation to the Mental Capacity Act 2005 or the associated Deprivation of Liberty Safeguards. The registered manager told us that this training was not mandatory for staff to complete. The activities co-ordinator had completed training in relation to dementia. However, they told us this had not been specifically covered how to provide activities to people living with dementia.

The staff we spoke with gave us mixed views as to whether they felt supported in their role. We checked two staff member's files. The first staff member had one documented supervision within their staff file and the other staff member had two, although these were not in relation to their role as care staff. There were no records to support that these staff had had their care practice assessed as being competent. We asked the registered manager whether this occurred. They told us that it did but there were no records to support this.

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

Most of the staff we spoke with told us they felt they had received adequate training to meet people's care needs. Staff had recently completed training in dementia, nutrition and hydration and pressure care management. The registered manager had checked that agency staff had sufficient training before they were able to commencing working within the home.

The people we spoke with told us they were supported to maintain their health. One person told us that when they were unwell that the staff called an ambulance and they were taken to hospital. Following discharge from hospital they said they had seen the GP frequently. Another person told us they had seen the dentist regularly in relation to a problem with their teeth. A further person told us how they saw the district nursing staff each day who supported them with their healthcare needs and an optician when they needed to.

A number of healthcare professionals regularly visited the home to support people with their care needs. This included district nurses, nurses from the local GP practice and the GP. Referrals were also made to dieticians and speech and language therapists when needed. However, we found on occasions that staff did not always follow the guidance of healthcare professionals. For example, one person was regularly being given a soft diet and we saw on one occasion, normal food when the SALT had prescribed them a pureed diet. Another person had not had a piece of equipment put in place as instructed to help the pressure be released from their heel which had an ulcer on it. A healthcare professional had advised the staff to remove a crash mat for one person's safety but this had not been done. Therefore, improvements are required in this

area to ensure that healthcare professional's advice is consistently followed.

We found that the design and layout of the home did not aid people to orientate themselves. This was especially for people who were living with dementia or a sensory impairment. The handrails were painted in a bright colour to help people see them and there was visual signage on the communal bathrooms and toilets. However, the doors to these areas were the same colour as the walls and so were not differentiated. We observed some people during the inspection looking confused and disorientated as they looked for the bathroom or toilet. Name plates were on the doors to people's rooms but there was no memory signage providing guidance for people living with dementia or sensory impairments.

We received mixed views from the three people we spoke with regarding whether their consent was obtained before they commenced a task. One person told us, "They don't always ask before they do something." Another person said, "The staff work very hard. They say 'if you want any help, just ask'." The third person told us, "Some of the agency men are sharp but the others will bring me anything I need."

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Most of the staff we spoke with understood the principles of the MCA. They were clear that they needed to offer people choice and to support them to make decisions for themselves. They knew that if they had to make a decision for someone that it had to be in their best interests. We observed this during the inspection. Staff always asked people for their consent before they performed a task. Where the person could not consent, the staff were seen supporting people to make day to day decisions about their care. For example, people were shown different meals to help them make a choice.

People's records contained information about their ability to make decisions for themselves and how the staff could support them although the amount of detail was variable. Assessments of people's capacity to make certain decisions had been made. However, these had not been regularly reviewed to check the person still lacked capacity to make that decision. For example, the last capacity assessment for one person in relation to personal care had been completed in March 2016. This meant that their current needs in relation to making that certain decision may not have been known.

The registered manager had assessed people living in the home to see if they were depriving them of the liberty. Where it was felt they were, applications had been made to the local authority for authorisation to deprive some people of their liberty in their best interests. They told us that these had yet to be authorised but that they kept them under review to make sure the application was still relevant.

Requires Improvement

Is the service caring?

Our findings

We saw some good examples of where people's dignity and privacy was preserved and they were treated with respect. For example, positive interaction was observed between one staff member and a person living in the home when they were found walking around the home with no shoes or slippers on. The staff member through gentle encouragement persuaded the person to move to a quiet area so they could be helped with their shoes. People's doors were closed when they received support from the staff with personal care. However, people's dignity and privacy not being consistently preserved.

During our observations around the home, we saw that three people's call bells were out of their reach. This resulted in them having to cry out for assistance when it was required which was not dignified. We asked a senior member of staff whether these people were able to use the call bells and they confirmed they could. They could not explain why they were out of people's reach. We checked two of these people care records. It was highlighted within this record in bold red writing that the call bells were to be near them at all times but staff had not adhered to this.

Another person was observed to be sitting on their bed with their hips fully exposed as their trousers were falling down. Their door was open and this was only corrected when the registered manager was alerted by an inspector.

Whilst speaking with one person about the care they received, they told us the staff had told them the reason they sometimes received personal care late in the day, was because another person living the home often delayed them because they were 'demanding' and 'difficult'. The person was very specific about the issues staff had told them about the other person's care needs. This breached the other person's confidentiality and their right to privacy. We also saw that this person's daily records had been left outside their door in a communal area which visitors to the home could view.

Some people were observed to be wearing stained and unclean clothes. One person was seen lying in bed during our inspection visit. On both days their top sheet was visibly stained with food and the floor of their room was unclean with crumbs of food on the carpet. A healthcare professional we spoke with after the inspection visit also raised this as an issue with us. Some staff told us that they often found people in wet or soiled beds when they went to give them personal care.

Most of the people we spoke with told us the staff were kind and caring. One person said, "Staff are very kind. The male carers are especially kind. They are very patient and when I can't move, they give me a little help." Another person told us, "They're all very good, very kind and helpful. They encourage me to look after myself. A further person said, "Mostly very kind and I can talk to them, but not the agency. The men can be quite sharp." The two relatives we spoke with said they felt the staff were kind. One told us how they had observed in the past the staff calming a person who was upset and distressed. They said, "The carers were brilliant and kept their cool. They weren't physical just used gentle persuasion." The other relative told us, "They're all quite good and cheerful but they need extra help."

Most people told us they felt the regular staff knew them well and that they knew the staff. One person said, "I've got to know them all so well. I respect them. They are more like friends. I can talk to them." A relative told us that they felt that certain staff knew their family member well so they could provide them with care in a way they wanted. All of the staff we spoke with who were permanent staff demonstrated they knew people well. They understood people's needs, personalities and life history to help them build relationships with people when they were able to do this.

When staff did interact with people we observed that this was conducted in a kind and polite manner. One staff member made a person laugh. Another made sure they got to the same level as the person when they spoke with them and gave them time to respond during a short conversation. Staff were seen explaining to people what they were doing when they were supporting them to move.

Most of the people we spoke with told us they were involved in making decisions about their care. One person said, "If I don't like something I tell them." Another person told us how they were consulted about their plan of care when they first arrived at the care home although they could not recall being asked about it recently. A further person said, "Yes I can decide. They know I like my independence and respect my wishes." However one person told us, "It's my home, but I don't feel involved."

When staff interacted with people, we saw them offer people a choice such as what to eat or drink or where to sit within the communal lounges, so they could make their own decisions. One staff member was seen to be kind and patient while a person decided where they would like to sit. The registered manager had recorded when they had conducted reviews of people's care with them and/or their relatives. We saw this list but the registered manager had not recorded the outcome of any conversations with people or relatives.

Inadequate

Is the service responsive?

Our findings

People did not always receive care that was personalised or responsive to their individual needs. Care had not been planned or delivered to meet all people's preferred needs or to enhance their wellbeing and protect them from the risk of social isolation. Five of the six people we spoke with told us either their personal preferences were not being met or that they received inadequate stimulation to enhance their well-being.

One person told us how their routine was fairly rigid and that they had to wait for staff to become available to provide the necessary assistance to them. This was confirmed by the person's relative who also told us they felt that their relative was demoralised and low. Another person told us that they enjoyed getting up early and spending the morning in the lounge and participating in the activities. However they said that because of low staffing levels, the staff were currently unavailable to assist with personal care until late morning. This meant that they did not arrive in the lounge until lunch time which was not their preference. They also told us at 10.55am that they had been waiting to have a bath since 7.30am and that they had had to wait for 90 minutes for their breakfast in the morning.

Another person said they felt that because of low staffing levels, the staff were unable to spend adequate time with them. They said this had an adverse effect on their wellbeing and they became tearful when they were telling us this. A further person told us that they 'felt very upset and tearful about everything.' They stated that they remained in their room and felt lonely. They advised that previously they had spent time in the lounge but found this difficult due to the number of people in the home who were living with dementia. This was echoed by another person who stated that they would only go to the communal areas for lunch and then return to their room. A healthcare professional we spoke with told us that during a recent visit, one person they were providing care for had told them they were lonely. Another person told us the staff knew their preferences and met some of these on a regular basis.

Three of the care staff we spoke with told us they could not provide care based on people's individual needs. They said that they felt the quality of care provided was poor and that people did not receive personal care when they needed it or adequate stimulation to enhance their wellbeing. One staff member described the level of care as 'a disgrace'. Another said that when the new manager had started in October 2016 that it had improved but that since they left, they felt it the standard of care was again poor. All three said they sometimes found people in wet and soiled beds or clothing. One staff member when asked, said they did not always have time to re-offer personal care to people if they had initially refused. We reviewed two people's personal care records. These did not support that people always received adequate personal care that met their needs.

One person's risk assessment in relation to personal care stated that they could on occasions, refuse personal care. It was recorded that should this take place that staff needed to encourage the person to have personal care and to try a different approach with a different carer or at a different time of day. The records showed that when the person had refused which occurred regularly, that staff had not always returned to offer personal care again.

Another person's pressure care risk assessment stated that the person required regular personal care checks throughout the day and their personal hygiene/skin care plan dated 6 December 2016 stated they required full assistance with personal care. Two of the staff member's we spoke with told us this person required assistance with personal care. However, the records regularly stated that the person had washed and dressed themselves and was independent with their personal care needs. Therefore, they had not received assistance with their personal care. No regular checks of this person's personal care needs had been recorded.

Two other people's care records noted that their personal care preference was to have a shower or a bath each week. However, the records showed that one person had only had one shower in the 21 days prior to our inspection. The other person had not had a bath within this time, receiving instead support with a daily wash in their room.

It was noted within one person's care record that they had been admitted to the home with two hearing aids. These were not in use on the day of the inspection. The registered manager told us these had been lost but then said the person had not been admitted with them. They confirmed that the person was not able to hear very well without any aids. We were aware that this had been raised as an issue by the person's relative and the registered manager advised us that they were seeking a solution.

We received mixed feedback from the four people we spoke with regarding how they were supported to maintain their hobbies and interests. One person told us how they enjoyed reading, cooking and making pastry in the kitchen. Another person said, "It is important to keep occupied. It helps the day pass quickly, but the new activity coordinator has not got into it yet." A further person told us, that the lounge was 'half empty and there's no one to converse with, so I stay in my room.' The final person we spoke with about this said they had lost interest in their previous hobbies of knitting and reading, and stated that they missed the previous activity coordinator who supported them with knitting.

During our observations we saw that the care provided to people was mainly task orientated and that staff had little time to engage with people in a meaningful way. Prior to the inspection we had received a concern that people were bored and unhappy and we found this to be the case.

The provider employed an activities co-ordinator who had put together a programme of events for people to join in with. Some of these were taking place during the morning on the first day of our inspection visit. These included jigsaws and puzzles. However, due to the lack of staff available the activities co-ordinator had to complete other tasks. These included the drinks rounds during the morning as well as co-ordinating two separate lounges for activities. This resulted in any activities taking part being regularly interrupted. We spoke with the activities co-ordinator who told us that in their opinion, they were unable to provide people with adequate stimulation or activities because they had to regularly perform other care duties due to a shortage of staff. The activities co-ordinator was not working in the afternoon or on the second day of our inspection visit and therefore, we did not see people having access to activities during these times.

In a separate dining room, we observed four people who were sitting at a dining room table. During our period of observation, they had little interaction with the staff. Two people had their heads on the table trying to sleep. Two others were seen either sleeping or staring around the room. They told us they were bored and that this was their daily routine. All of these people in this dining room were seen to be there for the whole of the first day of our inspection. On one occasion during the morning some of them were asked if they wanted to join in the main activities which they refused, but no alternatives were offered to them. There was a lack of tactile items for people to feel and touch to facilitate a feeling of activity and wellbeing.

People's care needs had been assessed before they moved into the home. The pre-assessment had been improved following our last inspection and had captured a number of areas in relation to people's needs. However, we found that the subsequent information in place to guide staff on how to meet these needs was variable. Some contained good information for staff. For example, one person had a care plan in relation to how staff could support them to manage their diabetes and how the staff could support them with their communication needs. However, this person's risk assessment in relation to personal care was not specific in relation to how often their personal care needs were required to be checked. It was recorded that this needed to be checked 'regularly' but this is ambiguous.

Some people did not have any care plans in place to guide staff on the care they required or some information within them was inaccurate. This was a risk as the home regularly used agency staff to provide care who may not have been familiar with people's care needs and therefore, the care plans would provide an important source of information. Two people who were living with diabetes did not have a specific care plan in place in relation to this. Another person's care plan in respect of their skin integrity, contained no information about a new piece of equipment the person needed to use to help reduce the risk of the person developing a pressure ulcer. Another person's mobility risk assessment stated they needed two staff and a stand aid to support them to move. However, on the first day of the inspection a hoist was used to move the person from their chair to the bed and on the second, a frame was used. It was not noted within their care record whether they had variable mobility needs. Another care plan in relation to a person's nutritional needs stated they required softened food but this contradicted other information that stated they needed pureed food. Their moving and handling risk assessment stated they did not have a hearing impairment when their admission form said they had hearing aids when they moved into the home and the registered manager confirmed they found it difficult to hear.

We also found that the assessment of people's preferences was variable. In some care records, a number of these had been captured however in others, there was no information regarding what time the person preferred to get up and go to bed or whether they preferred a male or female carer.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider told us they were aware that the provision of activities was not as it should be. They said in response to this they had recently recruited a further member of staff to provide people with activities on a part time basis. They also said that the new manager who was to start in the home shortly, had a number of ideas regarding how to improve this area. The staff told us that people were supported to follow their spiritual and religious beliefs with a weekly visit made by representatives of various faiths.

People's complaints were not always listened to or dealt with effectively. Five of the six people we spoke with told us they had either raised a concern with the staff or had a concern they felt they could not raise. Three people told us they had raised concerns in the past and had had a variable response. One person told us that the provider 'had just shrugged their shoulders' when they raised a concern. They added however, that the issue had been fixed. Another person told us that they had complained that their white underwear was being returned discoloured after they had been laundered. They said that after they had raised their complaint that nothing changed so they had asked their relative to get them 'some muddy coloured underwear' instead. A further person told us how they had raised a concern about staffing levels with the provider. They said that in response to their concern, "He shrugs his shoulders and says what can I do?"

Two of the relatives said they had cause for concern. One told us they did not know who to complain to. Another said they had complained that their family member's personal possessions kept going missing. They expressed their frustration over this situation as they had been 'unable to get any answers' regarding

failure of the staff to locate the possessions.

Two people told us they did not feel confident to raise their concerns about the care provided with the staff. One person said they had been made to feel uncomfortable about living in the home and so felt they could not raise their concerns.

We looked at how the provider recorded and dealt with complaints. We found that written complaints had been recorded, investigated and a response had been sent to the complainant. However, verbal concerns had not been recorded and there was no record to show what actions the provider or registered manager had taken in response to these. The registered manager confirmed they did not record verbal complaints. Improvements are therefore required within this area to ensure that people's views and concerns are adequately investigated and dealt with.

Inadequate

Is the service well-led?

Our findings

At our last comprehensive inspection of this home in May 2016, we told the provider they needed to make a number of improvements to ensure that people received good quality care. Following that inspection some concerns were received in relation to the care provided. We therefore also conducted a focused inspection in September 2016. After that inspection, we judged that the provider was in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014. Following the September 2016 inspection, we sent the provider a serious letter of concern regarding our findings and the provider sent us an immediate action plan that detailed the improvements they planned to make. They also sent us a further updated action plan in October 2016 where they stated they would be meeting these regulations by November 2016. However, at this inspection we found that not all of the improvements had been made and that others were not progressing in a timely manner.

The provider wrote to us and stated that following our inspection in September 2016, new daily notes had been put in place that were to be monitored on a daily basis by the manager. They said this had enabled any shortfalls to be picked up in relation to people's care and therefore, dealt with promptly. During this inspection, the registered manager told us these records were checked daily for accuracy and completeness. However, we found that a number of people's food, fluid, personal care, re-positioning and pressure care check records indicated that people had not received the care they required. Where this was the case, there was not always evidence to show that any improvements to the person's care had subsequently occurred. This demonstrated that this system was not effective.

Another action the provider said they would take was to offer people who were at risk of not eating, a second portion to boost their calorific intake. We did not see that this happened during the inspection. They also told us in their action plan that all people living in the home would have the necessary risk assessments in place. However, again we found that one person did not have a falls risk assessment in place when they moved into the home.

At our last inspection in September 2016, we found some people's care records were either incomplete or inaccurate. The provider told us after that inspection that they would correct this issue by November 2016. This issue had previously been raised with the provider following our inspection in May 2016 when we were told this would be corrected by June 2016. However, we found the same issues at this inspection. The registered manager told us that people's care records were audited and reviewed as part of the 'resident of the day' process but stated that only ten of these had been reviewed so far. We also found that some records in relation to people's care had not been completed and/or contained gaps such as some medicine records.

At the last two comprehensive inspections of the home in December 2014 and May 2016, we had identified that there were not always enough staff to provide people with personalised care or to offer activities to people to enhance their wellbeing. On both occasions we told the provider that these areas required improving but still found the same issue at this inspection.

We had mentioned in our last report in May 2016, that no formal recognised tool was used to calculate how

many staff were required based on people's individual needs. At this inspection, we found that the provider had not reviewed how they calculated the required staffing numbers and continued to use their previous system. This system was not effective at calculating how many staff were required to work based on people's individual needs. People therefore continued not to receive personalised care and in addition, were not always safe. In the action plan the provider sent us after our inspection in September 2016, they stated that they would employ adequate staffing levels at all times. However, at this inspection we found that this was not the case.

Sufficient improvements had not been made to the environment to help people living with dementia or a sensory impairment. This had been raised as an issue in both our comprehensive inspections we had conducted in December 2014 and May 2016.

At the beginning of this inspection, the registered manager told us that people were not losing weight. However, the four people whose care we tracked in detail showed that three of these people had lost weight and the other's had remained stable. An audit conducted by the registered manager in December 2016 showed that five people had lost weight during that month.

There was a training matrix in place to monitor the completion of staff training. However, there were gaps within some staff's training even when they had been working in the home for over three months. The provider had not ensured that the staff working on each shift always had the necessary training to ensure that people were safe. There was no system in place to ensure they had received regular assessments of their competency to provide people with safe care.

Regular checks in relation to the safety and cleanliness of the premises had been completed by the provider. However, they had failed to identify that hot, exposed pipes presented a risk to the people living in the home and we found some areas of the home and equipment people used was unclean. Therefore, the system in place to monitor the safety and cleanliness of the premises was not wholly effective.

The provider told us they were making improvements in relation to the cleanliness of the home and the control of the spread of infection. This was in response to an audit that had recently been completed by the local authority. We saw that some cleaning schedules for equipment and areas of the home had been developed but not yet put in place. The provider told us they were waiting for the new manager to start before these commenced. The local authority's audit had been conducted in November 2016 where they had also identified issues in these areas. Therefore, the action taken was not being implemented in a timely manner to ensure the home and equipment people used was clean.

An audit of people's medicines on 19 December 2016 had identified that the medicine administration records had not been completed correctly. The registered manager told us that the staff who had made the errors had received further training and we saw records to confirm this. However, further gaps were found in the records during this inspection relating to January 2017. We also noted that this had been recorded as an issue in an audit conducted in November 2016. This demonstrated that actions taken to correct this had not been effective at rectifying the issue.

There was no effective system in place to ensure that people's concerns were routinely acted upon and dealt with. Written complaints were dealt with but verbal ones had not been recorded.

One system in place to ensure people received the care they required was the daily staff handover. We sat in on one of these at 2pm on the first day of our inspection. The senior member of staff fed back any requirements in relation to people's care to the new staff coming on shift. However, although the senior who

was coming on shift was handed a document with all of this information on, none of the staff present at the handover wrote down any of this information. We subsequently found that some of the instructions given during this handover had not been implemented.

For example, it was stated that two people required extra fluids that afternoon. However, one person's record for that day showed they had only been supported to drink one drink at 3.30pm for the rest of the day and the other person only on two occasions after the meeting. A request was made for another person to be offered frequent meals however, their record in relation to meals for the afternoon and evening was blank. Therefore we have judged that the handover process was not effective at ensuring staff knew what action they needed to take to support people with their care needs.

Three people told us they thought the home was 'in a muddle' or 'disorganised'. Another person said they felt 'let down' and a further person said that the way the home was run 'got them down'. Two healthcare professionals told us that when they visited the home, staff often did not know why they had been asked to visit. They said it took staff sometime to direct them to the person who required their assistance.

We observed that there was not always clear leadership in place on the days of our inspection visit to guide staff or ensure they provided the correct care that people required to keep them safe.

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

We received mixed views from people and relatives when we asked them whether they thought the home was well-led and if they were happy living at The Laurels. One person said, "I'm happy here, I don't want to move." Another said they were happy with their standard of care. However, one person told us, "I have been happy here, but things have changed since I was ill. It's not the same." Another person said, "I've been happy here but I'm not sure now." A further person told us, "I can't say that I'm happy now. It's gone down. It's not the same as it was."

A relative said, "It's changed" but did not offer any further information. Another relative said, "I don't think so, no. Not how it is, they are so short of staff." Some healthcare professionals we spoke with told us they did not feel that the home was currently managed well.

There was a manager registered with the CQC. After our inspection in September 2016, they had stepped down from this role in October 2016 to work as the deputy manager. However, they had not de-registered with us. We asked the provider why this was. They told us they had been concerned that they would be in breach of regulations if they had taken this action. We advised the provider that as the registered manager had stepped down from their post that they should have de-registered with us. The provider told us a new manager was about to start working at the home and that therefore, they would send us relevant paperwork to ensure our records were correct.

People said they knew who the registered manager and provider were. However, some people and staff we spoke with told us they did not feel able to raise concerns about the care provided with them. Two of the four staff member's we spoke with about this said this was because they were not confident any action would be taken. This did not demonstrate an open culture.

Most of the staff we spoke with told us they felt they all worked well as a team but felt their morale was low. They said this was due to the lack of staff and that they were also concerned about the high turnover of staff. The provider had advised on their provider information return in December 2016 that 25 staff had left within

the last 12 months and we were aware that another two staff had left in January 2017.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people living in the service was not always appropriate and had not been designed to meet their needs and preferences. People's preferences on how they wished to be cared for had not always been established. Regulation 9, 1 and 3 (a) and (b).

The enforcement action we took:

We told the provider they could not admit any new people to the home from 24 January 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	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. Some areas of the home and equipment people used were unclean increasing the risk of the spread of infection. Not all areas of the premises had been adequately assessed to ensure they were safe. Some people's medicines had not been well managed. Regulation 12, 1 and 2 (a), (b) (d), (e), (g) and (h).

The enforcement action we took:

We told the provider they could not admit any new people to the home from 24 January 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who were living in the service were not

always protected from abuse or the risk of abuse. Regulation 13, 1 and 2

The enforcement action we took:

We told the provider they could not admit any new people to the home from 24 January 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs were not being met for all people living in the service to sustain good health. Regulation 14, 1, 2 and 4 (a) and (d).

The enforcement action we took:

We told the provider they could not admit any new people to the home from 24 January 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	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. Feedback from people had not always been acted upon .Regulation 17, 1 and 2 (a), (b), (c), (e) and (f).

The enforcement action we took:

We told the provider they could not admit any new people to the home from 24 January 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care. Furthermore, we told them that until further notice, they have to send us various reports in relation to the care provided to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Suitable numbers of suitably qualified, competent, skilled and experienced staff had not always been deployed in the home. Staff had not always received appropriate training, supervision or support to carry out their role. Regulation 18, 1 and 2.

The enforcement action we took:

We told the provider they could not admit any new people to the home from 24 January 2017 without the prior written agreement of the Care Quality Commission. This included people seeking respite care.