Defiant Enterprises Limited

The Laurels Care Home

Inspection report

West Carr Road
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Norfolk
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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 1 December 2014 and was unannounced. The service complied with regulations that were checked at our last inspection.

The Laurels Care Home provides accommodation and personal care for up to 51 older people, some of whom may be living with dementia. At the time of our inspection there were 46 people living at the home.

The provider of the service had a registered manager in place, as required by law. 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People said that they felt safe in the home and staff knew what they needed to report if they had any concerns someone may be being abused. Medicines were not always administered in a timely way.

People did not always receive sufficient amounts to eat and drink to meet their needs. Decisions about people's care and treatment were not made in accordance with

Summary of findings

the Mental Capacity Act 2005. One person's rights in relation to the Deprivation of Liberty Safeguards were potentially compromised because of the level of supervision to which they were subjected.

Staff had access to training, relevant qualifications and support to enable them to care for people. However, district nursing staff were not confident their advice about supporting people was consistently followed.

People said that staff treated them with kindness and our observations confirmed this. We saw that staff offered people comfort and reassurance when this was needed.

People had access to health professionals when they became unwell and staff sought advice promptly when their needs changed. Most people felt that activities met their interests and preferences and that there were regular opportunities to engage in something they enjoyed. People had confidence in raising concerns with members of staff and relatives knew how to make a complaint if they needed to.

There were systems in place to monitor the quality and safety of the service people received and to consult with people for their views. Staff were motivated and committed to meeting people's needs.

We have made recommendations about assessment and prevention of falls, catheter care and pressure ulcer prevention. We have also made a recommendation about environmental design for people living with dementia.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These regulations have been replaced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People said that they felt safe in the service and staff demonstrated that they knew how to keep people safe. Although medicines were stored safely and recorded appropriately, people did not always receive their medicines at the times the prescriber intended. Therefore, there was a risk to people's safety and that medicines would not be effective.

There were areas of the home where action was needed to reduce risks to people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Due to the lack of support provided there were risks that people may not always receive enough to eat and drink to meet their needs and preferences.

Staff had training in the Mental Capacity Act 2005 but did not consistently apply the principles and code of practice. The manager was aware of some of the Deprivation of Liberty Safeguards but not aware of recent updates so that they were consistently applied.

Is the service caring?

Good

The service was caring.

People received support from kind, respectful and compassionate staff. Staff offered comfort and reassurance to people when this was needed.

Is the service responsive?

Good

The service was responsive to people's needs.

People received care and support when they needed it and when their needs changed. People were able to pursue their interests and hobbies.

People were able to approach staff with any concerns and relatives knew how to make complaints about standards within the home if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's quality assurance system had not identified all areas where improvements were needed.

Staff were well motivated and were supported by the provider to give good care and support to people and to improve where necessary. People and their representatives were asked for their views about the service.

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.

The inspection took place on 1 December 2014. The inspection was unannounced. The inspection was carried out by 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 service, what the service does well and improvements they plan to make. We reviewed this information when we were preparing for the inspection.

During our inspection we spoke with 23 people who used the service although not everyone was able to tell us about their care because they were living with dementia. We spoke with 12 visitors to the home and eight staff including the deputy manager. We also spoke with the registered manager and three nurses from the local doctor's practice.

We observed the way that staff supported people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also made less formal observations while we were in the home.

We looked at records relating to the care of eight people using the service and medication records for 12 people. We reviewed staff recruitment records for two new staff members employed. We reviewed staff training records and records associated with the safety and maintenance of the home as well as the manager's checks on the quality of the service.

Requires Improvement

Is the service safe?

Our findings

We observed that one staff member was responsible for administering morning medicines and that these were still being given to people as late as 10.45am. The staff member who was administering medicines told us that the night staff tried to administer tablets at breakfast time which were prescribed for administration four times a day. This was so that there would be adequate gaps between doses. However, they said that this was not always possible, dependent on their work load.

Some people should have had their medicines administered at breakfast time as prescribed but were given them much later. This presented a risk that the medicines involved would not have the effect intended by the prescriber and presented a potential risk to their safety associated with the administration of doses too close together.

We observed that medicines were recorded and stored safely, when they were received into the home, when they were given to people and when they were disposed of. We found that there was good practice in that the medication administration records contained photos of people so that staff had an additional check that they were giving the correct medicines to the right people. Staff confirmed they had been trained to administer medicines and that this was updated regularly.

Staff made use of a formal and recognised system for assessing whether people living with dementia were in pain. This showed that staff considered what signs there were for people needing pain relief even if they could not express this verbally. We could see that the manager or deputy manager checked medicines regularly to ensure these were being properly accounted for and recorded safely.

People told us that they felt safe in the home. One person said, “Sometimes I get very nervous, but yes, I feel safe here.” People, who were able to tell us what they thought, said that they could talk to staff if they had any concerns about the way they were treated. We spoke with staff about what would lead them to think someone may be being abused. They were able to tell us about the different types of abuse vulnerable people might experience and were clear about the need to report any concerns to ensure people’s safety was promoted.

We saw that there were some risks associated with the safety of the premises. For example, vinyl floor covering in one corridor had bubbled creating a potential trip hazard. The manager told us that the provider considered this as low risk and had made arrangements to replace it. The assessment of risk for the area referred to the importance of staff monitoring the condition of the flooring pending replacement. However, it did not reflect whether anyone who lived at the home and mobilised independently (or with a mobility aid) was at any risk and if so, what action staff should take to reduce risks.

We had concerns about lighting in the ‘red’ lounge within the home. After dark we saw that this area was poorly lit so that contrasts between different items of furniture and floor coverings did not stand out well. This presented a risk that people living with dementia or with some visual impairment could not move around safely on their own. The manager had recognised this as an issue in the courtyard garden and showed us that the wooden garden furniture had been painted bright colours so that it would contrast with the paving slabs and brickwork. They acknowledged that lighting needed to improve in this lounge.

Relatives told us they felt the risk of falls was well managed. For example, one visitor told us that the person they visited had a number of falls at their previous care home but had not had any since coming to this home.

Care plans included an assessment of most risks to people and provided guidance about how risks were to be managed so that their safety was promoted. We noted that one person had been seen by an occupational therapist as a result of two falls which they had in November. However, their risk of falls had not been assessed within their plan of care and there was no specific guidance about the way staff should support and monitor the person to minimise the risk.

We observed that one person in a corridor had become confused and agitated because they could not find the toilet. An inspector and district nurse had to intervene to show the person where to go. There were no staff available in the vicinity to assist and the person did not have access to a call bell to summon staff for help. Members of the district nursing team also commented that sometimes, after they had completed people’s treatments, they could not always easily find staff to pass on information when they were leaving.

Requires Improvement

Is the service safe?

The manager told us what the expected staffing numbers were and we found that these levels were in place. The activities coordinator needed to cover catering duties as the cook was not available on the day of our inspection. Although another member of staff was allocated to support people with activities, we observed that they regularly needed to break off from these to attend to people's care needs.

Some staff told us that they were working long hours to maintain staffing levels. However, they felt this was not in excess of what they were willing to do or that staffing levels were unsafe. During our inspection we saw that one person who needed assistance got an immediate response from a member of staff and that no call bell rang for more than 45 seconds. We concluded that staffing levels were sufficient to meet people's needs safely.

The manager was able to tell us about the checks that were made when new staff were recruited. They showed us records supporting this so that we could see recruitment procedures were robust and contributed to protecting vulnerable people.

We recommend that the provider seeks advice and guidance from a reputable source about the assessment and prevention of falls in older people and about environmental design and adaptations for people with dementia.

Requires Improvement

Is the service effective?

Our findings

The majority of people we spoke with told us that they were happy with the food received. One person said, "It's not too much trouble for them to give me the food I like." However, some said the menu did not vary much and there was not always an alternative that they liked. There was no alternative main meal displayed on the menu for the day of our inspection. We saw that one person was encouraged to try the sausages they were given for lunch but said, "No, I don't like them." They were not offered an alternative promptly. Later, we saw that people who did not want the main meal were offered an omelette. Some people were offered gammon. Three people told us that it was not usual to be offered anything other than omelette or sandwiches.

We observed that some people needed their food to be processed to a soft consistency because of their swallowing difficulties. We saw that these meals were presented in a manner which did not look appetising, being of uniform brown appearance.

We found that the lunchtime routine was not well organised and a lot of food was returned to the kitchen as waste after lunch. Some people did not get prompt assistance to eat if this was needed. For example, we saw one person slouched back in their chair trying to eat their dinner. They did not manage this well on their own. Their food fell over their clothes and on to the floor. After about eight minutes trying to eat independently they gave up and fell asleep. We brought this to the attention of care staff. A staff member then sat with the person and gave them one piece of sausage to eat before the person said that they did not want anymore. The same person was not assisted to have a drink and was not assisted with their dessert although we found their care plan said they needed assistance to both eat and drink. This meant that the person was at risk of not eating and drinking enough because they did not get the support they needed.

We also saw that another person said to staff, "I'm waiting for a cup of tea or coffee." This was addressed to the staff member who had served the morning teas and coffees and was clearing away cups to the trolley. The staff member asked them which they would prefer but then wheeled the trolley away without serving them the drink they had requested. No one we were observing was offered a second drink during the morning or at lunch.

For people assessed as at high risk of poor nutrition, we found that their food intake records did not consistently show how much they had eaten to ensure they received the high calorific diet their care plans said they needed. We also reviewed fluid charts for six people to see if these showed whether people had enough to drink. The daily totals on these records were as low as 220mls and 260mls which did not show that people were properly hydrated. There was no 'target' amount of fluids indicated on the charts to provide guidance for staff about how much each person should be drinking. We asked the manager about this but they were unable to confirm whether this reflected inadequate fluid intake or recording errors.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff confirmed that they had training in the Mental Capacity Act 2005 (MCA). They knew that people should be offered the opportunity to make decisions about their care. However, we concluded from care records that the codes of practice for the MCA and those relating to the Deprivation of Liberty Safeguards (DoLS) were not properly applied. For example, one person's notes recorded that they had not got the capacity to make any decisions. Another person's records said they had been diagnosed with vascular dementia and were unable to make any decisions of their own. There were no assessments of capacity completed in accordance with the MCA relating to individual and specific decisions about their care. We found that three people's relatives had signed to give their consent to care or treatment on behalf of their loved one. The manager was not able to show that the relatives were legally entitled to give such consent by means of a 'lasting power of attorney' for care and welfare decisions rather than simply for the control of finances.

No one living at the home at the time of our inspection was subject to an application under DoLS to deprive them of their liberty. The manager was able to give us examples of when applications had been made before because there were restrictions on someone's freedom of movement. However, we found that one person was subject to continuous 24 hour supervision to prevent falls and was not free to spend time alone. A Supreme Court decision in relation to the DoLS in April 2014 gave the judgement that

Requires Improvement

Is the service effective?

an application needed to be made for consideration by the authorising body in such circumstances. The manager told us that they were not aware of the ruling and had not made an application to ensure the person's rights were protected.

These issues represented a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015.

People we spoke with told us they felt that staff understood their needs and were able to support them as they required. We observed that people received support with their mobility where this was required. Staff were able to tell us about clearly how someone needed assistance and about the equipment that was needed. People's records showed that their need for support with mobility had been assessed. This included a moving and handling assessment, an assessment of their balance and physical capabilities.

Visiting nursing staff confirmed that people were referred for medical or nursing support and advice appropriately and promptly so that they could receive the support with their healthcare that they needed. They told us that staff took action promptly after a person's skin condition had deteriorated to refer the person to their team so that they received the right treatment to aid their recovery.

However, two of the three visiting nursing staff told us that they felt that staff could do with more training to support people who had catheters effectively. They felt that staff were nervous of cleaning a catheter site when they provided personal care. They were also not confident that staff consistently followed their advice for individuals and best practice in skin care and the prevention of pressure ulcers.

We also found from our observation and from records that people assessed as at high risk of developing pressure ulcers were not always regularly repositioned to prevent their skin breaking down. For example, we saw that one person at high risk and unable to move independently, remained in the same position for four hours, increasing the risk that their skin would break down. We also found that another person at very high risk of developing a pressure ulcer had information showing the staff repositioned them during the night to relieve their pressure areas. However, we saw that they were not regularly repositioned during our inspection and there were no records to show that this happened regularly during the day time.

We reviewed the induction record for one new member of staff and found that training was undertaken promptly to ensure they had basic knowledge to meet people's needs. Staff spoken with told us they had undertaken core training to work with people effectively. This included training in first aid, moving and handling, safeguarding people and dementia awareness. Staff told us that they were also encouraged to undertake further vocational training. Details contained in the provider information return sent to us before our inspection, confirmed that the numbers of staff with further training qualifications was much better than expected for this type of service. However, the delivery of care in relation to the prevention of pressure ulcers, nutrition and hydration did not reflect that staff fully understood how to meet these needs.

The manager told us that they completed formal supervision of staff approximately once every two months and this was supported by the schedule we reviewed. Support to staff on shift was also available from the deputy manager who had considerable experience at the service. Staff felt that they could raise day to day issues easily with the deputy to ensure they were working with people effectively.

We recommend that the provider considers NHS and other guidance for patients about the prevention of pressure ulcers and management of catheters.

Good

Is the service caring?

Our findings

People told us they got on well with the staff team. One person said, "They are always there to help me. Nothing is too much trouble." We saw that staff gave people time to settle when they had assisted them to move. We also noted that staff supporting people to move using walking frames, assisted them at the person's own pace.

Relatives of people who were living with dementia gave very positive responses to our questions about whether the service was caring. One relative described the staff as giving care to people, "…like they were a member of their own family." Another told us that they had never had any concerns regarding the way that staff treated people and the person themselves said they were very happy with the staff. A relative described staff as being very kind and patient.

One person told us how they were involved in developing their care plan and talking about what support they needed. Relatives told us that the manager or staff were always available to speak to about people's care and that they were involved in reviewing care for their loved ones. We concluded this meant that they could support people to understand aspects of their care and treatment. Visitors also said that they were kept informed about people's health and welfare.

Throughout our observations we saw that staff spoke with people in a friendly, respectful and calm manner. We saw that staff got down to the level of people who were seated so that they could make eye contact and communicate with people effectively.

We saw that, when a person became anxious and tearful, staff intervened promptly to find out what was the cause and to offer reassurance. However, we also observed that a person became agitated with another, telling them to, "Get out and go away." The person on the receiving end of this said, "I know, I know" and became agitated themselves. Although staff did not intervene promptly at that point, a staff member was present at the table where these people later sat together. We saw that they chatted to people during their meal and no further incidents arose.

We saw that one person who had become upset and anxious showed no reluctance to approach the manager. The manager spent time sitting with the person, offering support, comfort, reassurance and explanation.

We noted that music playing in both of the lounge areas was from stations predominantly aimed at younger people. In one lounge when the station was changed, a person responded positively by singing along and stopped pacing through the room. We asked the person what sort of music they enjoyed. They said, "This sort." Staff recognised the person's reaction and then made sure that more suitable music played in that area during the last part of the morning and through lunch.

During our visit, we saw that staff respected people's dignity. People were assisted with personal care with minimum fuss and without drawing attention to any difficulties. However, we also noted that people had their nails clipped and cleaned in communal areas of the home rather than in the privacy of their own rooms or when they were receiving personal care.

People's spiritual needs had been identified within their care plans. In one case a person's record was partially inaccurate but senior staff and the manager were able to tell us about the person's chosen religion.

Good

Is the service responsive?

Our findings

One person told us how the provider had acted promptly to make changes they had asked for within their room so that it was better suited to their needs and interests. People who were able to tell us said that they could get up and go to bed when they liked. They recognised that sometimes this would need to be flexible depending on whether they needed staff to assist them. Staff told us that people could do things like laying the table or tidying their rooms if they wished and were able to do so. Staff spoken with, including those who had recently joined the home, were able to tell us about people's needs.

We found that care records were reviewed and updated regularly. They also took into account what people could do for themselves so that their independence was encouraged as far as practicable. However, we did see that some aspects of care were 'task orientated'. For example, we observed that everyone in one lounge area was assisted to the toilet before lunch; two of the eight care staff we spoke with explained their roles in terms of the list of tasks they needed to complete on each shift rather than for individuals based on their needs and preferences.

During our inspection at least a quarter of people living in the home received visitors and there were no restrictions on visiting times.

On the morning of our inspection we saw that one person was sitting at a table covered with large jigsaw pieces but was not doing anything with them. We asked them about this and the person said, "It's not my thing. I like needlework and crochet." People's care records contained a section to reflect their social needs, interests and hobbies but we did not see that this person's preferences and interests were met during our visit. However, we saw that other people did participate in activities they enjoyed. One person told us about their knitting and another worked on a jigsaw puzzle. During the afternoon the activities coordinator encouraged people to do some colouring for Christmas and one was going to give the picture to their granddaughter. The designs were largely childlike in nature so they would be easy for people to complete if they had some visual impairment or difficulty recognising fine detail. However, they would not necessarily have appealed to someone who had previously enjoyed artwork.

One person told us about their interest in history and how they liked to read about this. The person said that staff helped them with this. A new member of staff spoken with was aware of the person's interest and preferences. We saw a display of poppies and war memorabilia, which people had been encouraged to make and put together to commemorate the anniversary of the end of the First World War.

There was a noticeboard showing the different activities available throughout the week. These included craftwork, knitting, a church visit and board games. The activities were represented through words, pictures and photographs to help people understand what was available. Two of the people we spoke with said that they found it difficult to cope with people who were living with dementia. They said that was why they chose to stay in their rooms watching television, reading or in one case, using their computer. Other people said that they were happy living at the home and one person told us they had "…plenty to do."

We reviewed the findings of the most recent survey of 20 visitors to the home and found that the 19 of the respondents knew how to make a complaint if they needed to. The one who did not know was visiting someone who had moved to the home not long before the survey was completed and so may not have been aware of the complaints process at the time. Although some people living with dementia were not sure whether they would raise complaints with the manager, they told us that they could talk to staff. The relatives we spoke with during our inspection knew how to complain if this was necessary and could support their loved ones to raise concerns if it was needed. One person living in the home said, "I have every confidence that [the manager] would deal with things if there were issues."

Requires Improvement

Is the service well-led?

Our findings

The manager was able to give us examples of the checks that took place to ensure the service people received was safe and effective. However, these had not identified the shortfalls which the inspection team found at our visit.

For example, the management team made checks on medication to ensure there were no anomalies in medicine supplies and that medication records were complete. However, this monitoring had not identified that improvements were needed for the timeliness of administration of medication to improve people's safety. The manager told us how they audited care records. These checks had not identified whether improvements could be made to streamline recording systems, for example to ensure that dietary and fluid intake was accurately recorded. The audits had also not identified that care plans for people at high risk of pressure ulcers did not reflect repositioning as a key method of managing and minimising risk before pressure ulcers developed.

Although the manager was able to give examples of when applications to deprive someone of their liberty had been made, they had not kept up to date in respect of a Supreme Court judgement made in April 2014. This meant that one person's rights were potentially infringed. The manager had not applied to the local authority as the 'authorising body' to see whether the means of ensuring the person's safety was the least restrictive option and in their best interests.

The manager was able to tell us how they were reviewing and auditing care records to see how improvements could be made to the way people were supported to make informed decisions as far as practicable. However, there were some examples of consent being sought from relatives on behalf of people without proper assessment of the person's capacity to make the specific decision and without relatives being legally authorised to make decisions on behalf of those people.

People who were able to tell us felt that the manager would respond to their views and that they could speak with her if they needed to. They also said that the providers of the home were approachable and visited regularly. They told us they could express their views or complaints to staff and the deputy manager so that these could be passed on if appropriate. There were clear records of the investigations that the manager had made in response to complaints so we were satisfied that concerns would be addressed.

People were not able to confirm that they had any 'residents' meetings to discuss how the home was being run so that they could express their views. We found that other methods were used to gather people's views including the visits by the owners and questionnaires. The findings of surveys were analysed to see where there were shortfalls so that improvements could be made. The information sent to us by the manager before our inspection confirmed that the providers visited the home regularly and spoke with people living there. One person confirmed this and said that action was taken to address the things they raised. The manager showed us copies of the reports completed after these visits so that any improvements that were needed could be made.

Our discussions with staff showed that morale was good even though some staff worked long hours. They told us that they looked forward to coming to work. The deputy manager explained that they worked long hours by choice and so they were regularly present in the home to address any issues promptly with staff. Staff said that they felt that this person was approachable and accessible. Information obtained before our inspection showed that staff turnover rates over the last year were similar to expected levels for this type of service. Staff spoken with were enthusiastic about their work, clear about their roles and committed to ensuring the welfare of people who they were supporting.

There was a manager at the home who had been registered with the Care Quality Commission since February 2013. During our tour of the home and discussions with the manager it was clear that they knew the people who lived at the service and their visitors well. The manager could tell us about issues affecting people's welfare and health. Our discussions indicated that the manager was aware of their responsibilities for the day to day running of the home. We know from information we hold about the service that the manager also understood their legal obligations to tell us about specific events happening within the service, using formal notifications. There was also an analysis of accidents and incidents so that action could be taken to improve if there was a developing pattern.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People were not properly protected from the risks of not eating and drinking enough. This was because it could not be shown they received a choice of food and drink in sufficient quantities to meet their needs. People did not always have the support they needed to eat and drink. Regulation 14(1),(2) and (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent There was a lack of suitable arrangements for obtaining lawful consent to care and treatment, acting in accordance with the Mental Capacity Act 2005. Regulation 11(1), (2) and (3)