Victorguard Care plc

Laurel Bank Care Home

Inspection report

Laurel Bank Care Home
Main Street, Wilsden
Bradford
West Yorkshire
BD15 0JR

Tel: 01535274774
Website: www.victorguardcare.co.uk

Date of inspection visit:
10 July 2017
11 July 2017

Date of publication:
27 October 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Our inspection of Laurel Bank Care Home took place on 10 July 2017. The inspection was unannounced.

Laurel Bank offers care and support to people with a variety of care needs and has a residential unit and a dedicated unit for people living with dementia, called the Elizabeth Unit. The accommodation is set over three floor, with a lift and outside space. The Elizabeth Unit is based on the third floor of the service. On the day of our inspection there were 62 people living at the service.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Assessments to mitigate risks to people were in place. However, these were not always up to date or reflective of people's current needs.

Safeguarding processes were in place and staff understood how to keep people safe.

Although the service had a dependency tool in place to determine safe staff numbers, people, relatives, staff and health care professionals told us they had concerns about staffing levels. Call bells were not always answered in a timely manner. Staff appeared rushed and many interactions between staff and people were task orientated.

Safe recruitment procedures were generally in place to ensure staff were suitable to work with vulnerable people. Some staff training needed to be updated and we saw evidence of poor moving and handling practice.

We saw and people told us staff were caring but did not have time to talk or spend meaningful time with them. Regular staff knew people's care and support needs well, although staff who had been put on shift from another service did not. Some staff did not knock before entering people's bedrooms although most staff showed they respected people's privacy and dignity.

Medicines were not always managed safely. Although people generally received their medicines as prescribed we observed staff had not always ensured people had taken their prescribed medicines or taken appropriate actions when discarded medicines were discovered.

The service was mostly working within the legal principles of the Mental Capacity Act. More robust documentation needed to be in place regarding best interest decisions, consent and conditions relating to Deprivation of Liberty Safeguards (DoLS). However, a recent quality assurance audit had made

recommendations for all covert medicines were reviewed to ensure appropriate paperwork was in place.

Some people's care plans contained detailed and person centred information. However, other people's care records and assessments did not reflect people's up to date care and support needs.

People had a sufficient choice and a variety of food. Arrangements were in place to meet people's specific individual needs. Where required, referrals were made to the GP, community matron or dietician and measures put in place including monitoring food intake and prescribing nutritious supplements. However, some people's nutritional care plans and screening tools required updating to reflect current needs and better evidence of food and fluid intake was required.

People had access to health care professionals.

A wide range of activities were on offer according to people's choice although these were mainly based around the residential unit.

Complaints were documented with actions and analysis. However, some people and relatives told us they were concerned how their concerns would be treated if issues were raised.

A range of quality assurance processes were in place. However, these needed to be more robust to identify issues found at inspection.

Feedback was mixed about staff morale and the approachability of the management team.

Regular staff and residents meetings were held, which were used to help make improvements to the service.

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we asked the provider to take at the back of this report.

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

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Assessments to mitigate risks to people were not always up to date and reflective of people's current needs.

People, relatives, staff and health care professionals raised concerns about staffing levels. Call bells were not always answered promptly.

Medicines were not always managed and administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Although a range of training was in place, staff did not always follow best practice.

Documentation was not always reflective of actions taken, such as regarding weight loss and dietary intake.

Appropriate applications had been made for Deprivation of Liberty Safeguards (DoLS). However improvements were needed to recording of consent, best interests and conditions of DoLS. Recommendations about covert medicines had been made following a recent quality assurance audit.

Is the service caring?

Requires Improvement

The service was not always caring.

Regular care staff knew people well.

Although we saw some kind and caring interactions, many of these were task focussed.

Staff did not always respect people's privacy.

Is the service responsive?

Inadequate

The service was not responsive.

A dedicated activities co-ordinator was in post and people praised the activities on offer.

Care plans were not always updated and reflective of people's care and support needs.

Complaints were documented and analysed for trends and lessons learned. However, people did not always feel complaints or concerns would be addressed if raised.

Is the service well-led?

Inadequate

The service was not well led.

Staff morale was variable.

Some staff and relatives expressed concerns about the approachability of the management team.

A range of audit and quality processes were in place. However, these were not always sufficiently robust.

Laurel Bank 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.

Our inspection of Laurel Bank took place on 10 July 2017 and was unannounced.

The inspection team comprised two adult social care inspectors and two experts-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. The experts-by-experience used on this occasion had experience of older people and dementia care.

Prior to the inspection, we reviewed the information we held about the service. This included reviewing notifications received from the provider and contacting the local authority safeguarding and commissioning teams. As part of the inspection planning, we asked the service to complete 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. This had been returned in a timely manner and we took the information within the PIR into consideration when making our judgements.

During our inspection we used a number of different methods to help us understand the experiences of people who used the service. We spoke with 17 people who used the service, seven relatives, 15 care and senior care staff, the cook, the activities co-ordinator, the registered manager, the provider, the maintenance manager and a visiting health care professional. We observed care and support in the communal areas of the home and carried out a Short Observational Framework for Inspection (SOFI). SOFI is used to observe care, support and interactions with people who use the service who may not be able to speak for themselves. We looked at 10 people's care records, some in detail and others to check for specific information, medication records and other records which related to the management of the service such as training records and policies and procedures.

On the day following our inspection we spoke with a second health care professional and reviewed additional information provided by the registered manager and provider.

Inadequate

Is the service safe?

Our findings

People living at the home and relatives raised concerns about the amount of staff deployed to keep people safe. People living at the home told us, "You often have to wait for things when they are short staffed", "I get fed up of waiting; staff say they will do it in a bit, but then don't", "I have to say, there are not enough staff", "Even the staff say there are not enough staff," and, "Even the staff complain to me about the staff shortages."

Comments from relatives included, "Most times, especially afternoons and weekends there are only two on (Elizabeth unit)", "The staffing levels are very low at weekends", "Sometimes when I come there are no staff to be seen", "I just don't think there are enough staff at times; it varies so much," and, "My concern is that there are often members of staff, they are in the rooms hoisting and no-one is watching the others. It can be at least 20 minutes." Two relatives told us how they had intervened to assist people when no staff were around, for example to prevent falls and assist people with drinking fluids. One relative told us, "I find myself helping others (people) and feeding others (people)."

Staff told us safe staffing levels were not always maintained and there was a high turnover of staff. On both the Elizabeth unit and the residential unit, staff told us there had been a number of issues with staffing and there were occasions when there were not enough to keep people safe. For example, a staff member commented, "Staffing is the worst problem, most of us do extra shifts," and another said, "The lounge is unattended more than once a week and we can't feed everyone at once. You can have five residents; where do you start?" They went on to add, "If two are putting someone to bed or getting people up, it takes time and there can be one or no-one on the floor." Another staff member commented, "The residents are so dependant; it is sometimes a struggle," and another said, "I am fed up of complaining about safety issues; nothing changes." However, staff told us they felt the staff worked hard as a team when staff levels were low and one staff member commented, "Sickness is the only reason we haven't enough staff."

Normal staffing levels on the Elizabeth unit during the day were three care workers and one senior care worker who was responsible for medicines administration. Staff told us occasionally they were supported by a fourth staff member at breakfast time which was needed for the smooth operation of the unit. Two staff members told us that there had been a number of occasions when there had only been two care staff on the unit to care for the 15 people who lived there. Staff said seven people on this unit required two staff members to support them to move and with their personal care which meant that communal areas could not be appropriately supervised. One staff member told us that baths and showers did not always get completed, because this would mean leaving people unsupervised in communal areas. We looked at the documentation about people's care and saw a number of people were marked as having refused a bath or shower. A relative of a person on the Elizabeth unit commented, "It's not good enough. Three is the minimum on here. When two take people to the toilet, if someone else wants to go, there is no-one. On one occasion one lady wanted to go, the staff were at the bottom end (of the corridor) and a fight was going on between two ladies. I intervened because there was no-one (staff) there."

The registered manager showed us a dependency tool in place which they sent to the provider on a weekly

basis and staffing levels were assessed against this. We looked at the staff rotas and saw a mixture of care staff, senior care staff and team leaders were deployed between the units. We saw some days where staffing levels were lower than others. For example, on two recent occasions, there should have been four care staff and one senior care staff on duty during the night period and only three care staff and one senior care staff were deployed. A staff member told us, "People are getting left. You can't give care here. You can't safeguard; not enough staff to do it. One night we didn't feel safe. They told us agency were coming in but no-one came. We get that all the time."

As part of our inspection we spoke with two health care professionals who both expressed concerns about staffing levels and the impact on people living at the home. One commented, "You're very lucky if you can find someone to help you; staff are very busy."

During the inspection, we observed staff were hurried and task orientated and did not spend time in meaningful social interaction. For example, as part of the inspection, we asked to speak with a member of staff who apologised and told us they did not have time to do so and said, "We're just so busy." We asked them if there were enough staff deployed and they said, "No." We saw one staff member assisting five people to drink fluids, moving hurriedly from one to the other without meaningful interaction. We did not see staff spending time with people in the lounge areas apart from when completing tasks such as assisting with fluids.

Staff told us they worked between the floors if staff levels were low on a particular unit. The registered manager told us they had needed to use agency staff recently and also were able to deploy staff from the other homes if needed. On the day of our inspection we saw two members of staff came on duty in the morning who normally worked at the provider's other services and another staff member came for an afternoon shift who told us they had not been on the rota, but had been asked to come in. The provider told us the staff member had been asked to come in due to another member of staff having to leave their shift early. When we asked a staff member from the provider's other home about how they offered care and support to specific people. They commented, "I don't know. I don't normally work here." However, they also told us, "I would go to a senior if I had a problem." Some people remarked that some of the staff on duty during the day of inspection were not regular members of staff. One person commented, "A stranger came to get me up this morning; (staff member) knew nothing about what I need," and another told us, "I dread it when I hear that the agency staff are working; they don't know me or my needs." A relative commented, "I think some staff have been brought in from another home."

We spoke with the registered manager and provider about our concerns about staff levels. They confirmed they were reviewing changes to the staff shift pattern and told us they were awaiting DBS confirmation and references for 10 new members of staff. However, we were concerned about staffing levels and how the service had got to a point where there was such a high vacancy rate and the recent high turnover of staff, which equated to over 16% of the care staff team.

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

People we spoke with had differing opinions about if they felt safe living at the home. Comments included, "I don't like it here anymore; some of the staff are smashing, some don't make me feel safe", "I do not feel secure here", "The staff make sure I am safe", "I was not safe at home; me and my children feel so much better now I live here", "I am safer here than when I was at home. I like my room; it is my safe haven", "Yes, very (safe)." One relative told us, "(Relative) is safe. (Relative) is generally well looked after." However, another relative commented, "I am not at all confident that (relative) is safe at all times."

Staff had received safeguarding training and staff we spoke with were able to explain what they would do if concerned about potential abuse. Appropriate safeguarding referrals had been made and accidents/incidents were reported.

Risk assessment documents were in place but we saw they were not always consistently updated. We saw that some care plans, falls risk assessments, nutritional risk assessments and skin integrity risk assessments had not always been updated monthly in line with provider policy. We saw some risk assessments on the Elizabeth unit had not been updated since March and April 2017. For example, one person's nutrition and skin integrity risk assessments had not been updated since April 2017 and their nutritional risk had now changed. This meant that changes in people's needs and level of risk were not always identified and used to inform updated plans of care.

Antecedents Behaviour Consequence (ABC) charts were in place where people exhibited behaviours that challenged. These are charts used to record behavioural concerns. A staff member told us how they had completed an ABC chart for a person following a recent incident. However, they told us, "The ABC is in the file but (registered manager) didn't know about it. I'm concerned that the ABC just sits there in the file."

When we looked at incident records of falls, incident descriptions were not always detailed enough, and it was not always clear whether staff had been present or whether staffing levels had been considered as a possible factor. The 'actions taken' section of many of the incident forms was blank, meaning there was no evidence that action had been taken to investigate or help prevent these incidents in the future. In addition, as risk assessments and care plans were not always up-to-date, they had not always been updated following incidents such as falls. For example, we saw 13 of the 35 falls recorded in June 2017 related to one person. However, we saw in their care records that only six falls had been recorded on the falls monitoring chart for June and July 2017. Their mobility care plan had been updated on 27 June 2017. The updated care plan had not taken into account all the falls as only six had been recorded in the person's care records. This meant this was not a full assessment of their needs.

This was a breach of Regulation 12, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Medicines were not always managed safely. For example, although people generally received their medicines as prescribed we witnessed one incident which gave us cause for concern. While we were speaking with a person in the downstairs lounge area, they told us they had noticed a tablet lying on the floor and notified a staff member who picked it up and left it on the coffee table next to the person. The staff member did not remove the tablet and it remained on the coffee table whilst we were speaking with the person. When another staff member came into the room we pointed it out and the staff member took it away. We were concerned that the initial member of staff who had been alerted had not immediately removed the tablet safely and of the risk of someone taking this unknown tablet had we not intervened. This also meant we could not be sure all people had received their medicines as prescribed.

This was a breach of Regulation 12, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Medicines were administered by senior care workers who had received training in the safe management of medicines. We spoke with a senior care worker who confirmed they had received in depth training. They were competent in their role, confidently answering the questions we asked about people's medicines.

Medicines were stored securely within locked medicine trolleys within locked rooms. Some medicines were stored in fridges and these were appropriately secured. The temperatures of clinical rooms and medicines fridges were monitored daily and records showed safe temperatures were maintained.

Medicine Administration Records (MARs) were well completed and provided evidence people consistently received their medicines. Stock balances of medicines were checked and recorded each day to help identify any discrepancies. We counted a selection of medicines and found the number in stock matched what records stated should have been present. Some people require their medicines at set times of the day or on irregular days. We saw arrangements were in place to ensure these were given appropriately and in a timely manner.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw controlled drugs were stored correctly and appropriate records of their administration were kept. People received these medicines as prescribed.

Some people were prescribed topical ointments. Care staff applied these after personal care and records were kept in people's rooms. Overall these records were appropriately completed, although were saw some gaps on these MAR charts. We saw this had been identified by the registered manager through a recent audit and action was being taken to address this.

Where people were prescribed 'as required' medicine, for example for pain relief or behaviours that challenge, protocols were in place to support their safe and consistent use.

The premises was safely managed and suitable for its intended purpose. There were appropriate amounts of communal areas where people could spend time including dining rooms and lounges. Bedrooms were personalised and decorated to a good standard. A system was in place for staff to report any building related faults and these were rectified by the maintenance team. Environmental checks and audits were undertaken and we saw these were effective in identifying and rectifying issues with the building. Key safety checks were undertaken on systems such to the gas, electric and water systems to ensure they remained safe. A fire risk assessment was in place. Fire control measures including a sprinkler system were in place and regular checks and maintenance took place on the fire system and equipment.

We reviewed four staff files and in most instances we found appropriate recruitment procedures were in place to ensure people employed were safe to work with vulnerable people. However one person's application form showed they had listed the registered manager of the care home where they had previously worked as a reference and records showed there was no reference received from this person. This meant the service had not obtained satisfactory evidence of the conduct of this person in their previous employment in care.

Requires Improvement

Is the service effective?

Our findings

A range of training was in place and the provider utilised a training matrix to determine when staff training updates were required. This included infection control, fire safety, food hygiene, first aid, nutrition and hydration, Mental Capacity Act, dementia care and management of violence de-escalation.

We saw recent safeguarding training had been provided by the local authority. However, we saw a number of training areas which the provider had classed as mandatory for staff had not been attended by all required staff or the training had lapsed. For example, 26 care staff had either not yet completed training or their training had expired on management of violence de-escalation and 15 care staff had not completed the training on nutrition and hydration in the elderly.

We saw staff had received training in safe moving and handling practices and three staff members were qualified to train staff in this area. However, during our inspection, we observed two members of staff commence to 'drag lift' a person in the downstairs lounge in order to assist them into a wheelchair ready for lunch. Once they noticed we were observing they stopped what they were doing and later used a transfer belt for the manoeuvre. We were concerned this bad practice would have taken place had we not been observing and demonstrated staff were not always using best practice or training guidance.

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

Staff were subject to annual appraisal and regular supervision and a matrix was in place to show when these had taken place. The registered manager told us they aimed to complete these quarterly, although we saw some had yet to be completed for the quarter ending at the end of June 2017. They told us they were aware of the need to improve the frequency of these and plans were in place to bring these up to date.

People had a sufficient choice and variety of food. People were asked each day what they wanted to eat from a choice of several options. At breakfast time, cereals, toast or a cooked breakfast was available. Lunchtime consisted of a choice of light options followed by a dessert. The main meal was provided in the evening time and people had the choice of two main meals. If people did not like any of the main options available an alternative menu was available. Menus rotated on a three weekly basis to ensure people had sufficient variety. We looked at the menu which showed people received a sufficiently balanced and nutritious diet. However, most people told us they thought the food could be improved and many commented that the presentation was poor and food was often lukewarm or cold. Comments included, "They are just normal; just ordinary", "There is not enough fresh veg or fresh fruit", "Sometimes the food is cold; if you have to be helped with eating it is cold by the time they get round to giving it you", "Sometimes it's (the food) cold; they just slop it on the plate", "The pie today was awful; an eight year old could have made it; it is always like this," and, "The food is always cold and tasteless." A relative commented, "Good presentation (of food) goes a long way; that's all that's wrong with it," and another told us, "Staff feed residents but there is a lack of staff; there are not enough to feed them."

We observed mealtimes in both units at the home. On the residential unit, staff were calm and patient when

assisting people to sit at the dining table. However, we observed one person was asleep when the lunchtime meal was placed in front of them. The staff member put the plate down on the table, put a fork under the pie and walked away without informing them it was there or attempting to wake them. Only when another staff member took a hot drink 10 minutes later, did the person rouse and see their meal. This meant the food was cold when the person commenced eating. We also saw many drinks were left in the glasses at the end of the meal and we did not observe staff encourage people to drink fluids during the meal.

We saw at breakfast time one person complained about not having their dentures in place. They said, "I cannot eat properly without them." We saw they had tried to eat their breakfast toast but had eventually left it. We raised this with staff who said they would look for the dentures. However, when the person's main meal was delivered at lunchtime, these still had not been found and a staff member told us, "We are still looking for them." We were concerned staff did not have enough regard for the person's wellbeing to enable them to enjoy the food they wanted to eat. The staff member also told us, "I am only working here today (from another home) I am not sure what everyone has; although there is a list." We saw the person was still without their dentures later on that afternoon.

After breakfast time in the Elizabeth unit, we observed a staff member assisting people who were sleepy to drink in the dining room. They were the only staff member with five residents. We saw they sat at a table between two people, giving each of them sips of fluid in turn, before moving between the others and giving them a few sips of their drink. Although we saw they were attempting to encourage fluids, there was no meaningful social interaction and the staff member appeared rushed. At lunchtime, we observed people eating desserts in the dining room, some of whom were sleepy and were not attempting to finish their meal. No staff were present for the ten minutes we remained. A relative told us, "Staff are caring but they can't feed everyone at the same time. They feed two at a time."

Arrangements were in place to meet people's specific individual needs. For example some people required food to be of a certain consistency and arrangements were in place to ensure this information was passed to kitchen staff. One person required a gluten free diet and the chef made individual meals and desserts for this person. Food was fortified with milk and cream and nutritious snacks including fruit, freshly made cakes and milkshakes were also provided to boost people's nutritional intake.

We spoke to one person's relative who told us, "(Relative) has lost a lot of weight in six months." The relative told us their concerns and the amount their relative had lost in weight and said, "(Relative) won't eat." We asked if their relative was being given high calorie drinks and they said, "The doctor is going to see her; don't they have to be prescribed?" They also told us, "They (staff) know I am worried about the weight loss; we're waiting to see the doctor. They didn't raise the issue."

People's weights were regularly monitored and we saw instances where people had lost weight, appropriate referral had taken place to the community matron, GP or dietician with measures put in place including monitoring food intake and prescribing nutritious supplements. However we saw one person had lost nearly nine kilogrammes in weight since March 2017. Their nutritional screening tool had not been updated since April 2017 and showed them as low risk when if it had been re-calculated it would have shown high risk and that intervention was needed. Their nutritional care plan had also not been reviewed since April 2017 and stated they were maintaining a good weight. Therefore an up-to-date assessment of this person's needs was not in place.

Staff were able to tell us about one person who was losing weight, although one staff member said the doctor was supposed to be coming to see the person and another said they had already been seen. We found no evidence recorded in this person's care records that this person had been referred to health

professionals to investigate this weight loss or an appropriate plan put in place to help them increase their weight. We concluded this shortfall was due to a lack of review and oversight of this person's care plan which had not been updated since April 2017.

We also saw one person was having their fluid intake monitored. We saw they had only consumed 140mls of fluid on 8 July 2017 and 770mls on 9 July 2017. There was no target fluid intake for this person based on their weight and this low input had not been flagged up by staff demonstrating a lack of review of the fluid intake charts. A relative told us, "They bring juice but it's just left." The registered manager showed us a check list completed indicating jugs of water were taken during the morning to people's rooms and delivered when staff entered to assist with personal care. When these were collected by night staff they were replaced by a full glass of water. We saw jugs of fresh water outside and inside some bedrooms. However, we observed some fresh water jugs were still waiting outside people's bedrooms to be delivered after 10.30 a.m. We also saw in one person's room on the Elizabeth unit there was no glass or beaker for them to drink from.

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

In other instances we saw appropriate referral had taken place to health professionals including the GP, community mental health team and district nurses following incidents or changes in people's needs or conditions. For example, one person had fallen the night previously and the service had liaised with external health professionals over control measures and a bed rail assessment was to take place.

We spoke with two health care professionals who told us communication was an issue with the service. However, we saw meetings had been arranged to discuss and reach agreement about how this could be improved.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The management team had a good understanding of DoLS and we saw appropriate DoLS applications had been made for people who lacked capacity and the registered manager believed were being deprived of their liberty. 12 DoLS authorisations were in place, with 19 other applications awaiting assessment by the supervisory body. When DoLS expired, we saw reviews took place and further applications were made to the supervisory body. However due to backlogs within the supervisory body these were not always re-assessed in a timely way.

Some DoLS authorisations had conditions attached. We looked at a sample of these and saw evidence they had been complied with. However, we found there was currently no system in place to track and monitor whether conditions were being complied with, which meant there was a risk this could be overlooked. We

spoke with the registered manager about this who agreed to put arrangements in place to ensure this could be more robustly monitored in the future.

In some instances we saw best interest decisions had taken place where people lacked capacity; for example, relating to the provision of bed rails. However two people were receiving their medicines covertly. Although we saw evidence the GP and pharmacist had written letters supporting covert administration, a best interest process had not been followed in line with the MCA to demonstrate this was in the person's best interest. During the inspection we saw immediate action was taken to rectify this shortfall and ensure a best interest process was followed. The quality manager had identified about one person's documentation regarding consent at audit. They had made recommendations that all covert medicines were reviewed to ensure appropriate paperwork was in place. However, we saw better documentation and oversight relating to obtaining consent from people needed to be put in place. More robust recording and governance was needed to ensure these issues were addressed.

Adaptions had been made to the environment on the Elizabeth unit to make it dementia friendly. For example, contrasting colours were used for toilet doors to make them stand out. Memories and pictures were displayed throughout the floor and there were points of interest including an old style café and mannequins dressed in historic attire. People's bedroom doors included memories and pictures to help people identify with their bedrooms.

Requires Improvement

Is the service caring?

Our findings

We asked people what they thought of the care provided at Laurel Bank. Some people said that staff were good at listening to them and meeting their needs. Comments included, "Most of the staff are alright; they look after me", "Some of the staff know just what I like", "We all enjoy it. There are a few (people) dotted around that you can have a chat with", "They (staff) are alright, they are nice," although the same person indicated there were only very few staff members around and said, "I don't see many."

Some relatives commented positively about the staff and said, "Staff are wonderful; (relative) is always content. From the first day (relative) was happy to go in the lounge", "Some of the staff are so caring and kind", "Very happy with the care received", "The care staff are lovely, not just with (relative). What I see, I like", "The staff here are really helpful", "They are all very kind to (relative)." However, other relatives told us, "I have no confidence (relative) is getting the care (relative) needs," and, "I come at different times of the day so I get a good idea of what's going on. Some of the staff are great; others, not so," and, "Some staff are very good; some just sit and gossip."

We observed care and support and saw some positive and caring interactions. People looked comfortable in the presence of care staff and we saw exchanges of banter and laughter between some people and staff. Staff engaged with people in a kind and friendly manner and treated them with dignity and respect. A relative commented, "All staff are respectful."

We saw staff offered gentle encouragement to people to help them with tasks such as mobilising and eating and drinking. This was done in a warm and inclusive way.

However, we also observed some interactions were mainly task focused with care staff having little time to sit and talk to people and engage in meaningful activity or conversation. For example, we saw a staff member assisting a number of people with their fluid intake at the same time which did not reflect personalised care. We also observed staff had little time to sit with people to offer encouragement over mealtimes.

Staff confirmed they were always very busy and care was very task focussed. One staff member told us they thought people did not always have enough to do. We observed people were often left alone in the communal areas with no staff interaction and a number of people fell asleep or entered into a withdrawn state.

We saw staff mainly respected people's privacy; for example, most staff knocked on bedroom doors before entering. However, on three other occasions when we were speaking with people in their private rooms, staff entered without knocking.

Staff we spoke with demonstrated a dedication to ensuring people were well looked after. Staff on the Elizabeth unit were assigned to usually work in that area to ensure familiarity with the people they supported. Regular staff members we spoke with demonstrated they knew people well. One relative who

had earlier expressed concerns to us about the lack of a formal care planning meeting came back later in the day to tell us how impressed they were with a staff member's knowledge of the care and support needs of their relative. They said, "(Staff member) was spot on."

We saw some care records contained information about people's end of life needs. One relative told us, "I've had an end of life discussion with the GP."

Religion or belief is one of the protected characteristics set out in the Equalities Act 2010. Other protected characteristics are age, disability, gender, gender reassignment, marital status, pregnancy and maternity status and race. We saw arrangements were in place to support people's religious beliefs and fortnightly church services were held. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Inadequate

Is the service responsive?

Our findings

Each senior care worker had responsibility for maintaining and updating a number of care plans. We saw some updated care plans, particularly on the residential unit contained good information about people and their care and support needs. However, we saw improvements need to be made with person centred care planning in others. Whilst some care plans were reviewed monthly in line with the provider's policy, others were not kept up-to-date. This posed a risk to people, and meant they did not always have an up-to-date assessment of their needs. For example, one person's care plans including nutrition and skin integrity risk assessments and care plans had not been updated since April 2017 and their nutritional risk had now changed. Another person's mobility care plan had not been updated since 31 March 2017 although they had had three falls incidents in June 2017. This meant some care plans were not reflective of people's current needs.

Some people received regular pressure relief during the night to reduce the risk of pressure sores. The pressure sore audit from July 2017 showed four people had pressure sores in the home at the time of our inspection. We saw appropriate actions were in place with one of the actions being regular repositioning. However, care plans did not state how often people were to be turned which meant we could not always establish whether interventions were occurring at the correct frequency and if pressure areas were being appropriately managed. One person's relative told us their relative was supposed to receive half hourly checks but these had been missed on 8 July 2017. They said they had found their relative, "Wet through and the curtains still closed at 11.15 (a.m.)." This meant people were not always receiving care appropriate to their care and support needs.

We asked a relative if they or their relative had been involved in any formal care planning or reviews of care and they told us, "I've had no formal reviews. (Staff member) is (person's) senior carer. We need to do a plan; we never have done." Another relative told us, "There have been no care plan reviews." This confirmed the lack of care plan reviews we saw in some people's care records.

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

People commented about the length of time taken to respond to call bells. One person commented, "If I use the buzzer it can be a while before the staff come to you" and another told us, "It seems a long time before the staff come to you when you call for them." A relative also commented, "If the nurse call is sounded the staff never come straight away; people wait a long time for help." One staff member commented, "I used the call bell for assistance recently; it took 45 minutes for someone to come." The majority of feedback from people and relatives reflected staff's attitude was task focused rather than responsive to people's needs. A relative commented, "Staff don't sit and talk (to residents)."

The registered manager told us the call bell response target was three minutes. We looked at the call bell response over a three day period, including a weekend and found multiple instances where the time taken to respond exceeded this by several minutes. For example, on 8 July 2017, there were 15 instances of people

waiting for over 10 minutes and out of these, five people waited over 25 minutes and one for an hour. Again, on 9 July 2017, there were 17 instances of people waiting for over 10 minutes including five waiting over 25 minutes and one for one hour and 16 minutes. On the day of our inspection, we saw five recorded instances of people waiting over 10 minutes for a response. A staff member told us, "The staff (today) have been told to make sure they answer the buzzers quickly." This showed us call bells were not responded to in a timely manner and evidenced there were not sufficient staff deployed to ensure people were provided with timely and responsive support.

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

Complaints were documented with a monthly overview. These included information on actions taken and analysis including date of complaint, date of response, nature of the complaint, the response given, actions taken and learning points as a result. We saw four complaints had been documented since January 2017. However, we were concerned that some people felt unable to raise concerns or complaints. One person told us, "I won't complain now; I worry about animosity." A relative commented, "(Relative)has no problems, but I would be nervous at discussing concerns with the manager," and another said, "We have complained; we complained to the local authority, nothing is changing here." A staff member also commented, "We are all told to report any concerns we have straightway but nothing is done when you do report your concerns." We discussed our findings with the registered manager who told us they were surprised by the concerns raised since they felt they were open and responsive if concerns were raised.

This was a breach of Regulation 17, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

A full time activities co-ordinator was in post. A range of activities were in place. Activities took place in the morning and afternoon, dependant on people's choices and these were documented on a daily activities log. During the morning of our inspection we saw the activities co-ordinator set up a colourful and decorative cart from which to sell sweets and confectionaries. We observed people using this throughout the day. One person told us, "I love to see this cart; it looks fantastic." During the afternoon we saw a number of people enjoying a game of bingo. People were actively engaging and enjoying each other's company.

People and relatives praised the activities organiser. Comments included, "The activity worker is lovely", "The activity organiser is very dynamic", "The activity worker has made a big impact on my mum and has helped her settle in well," and, "The activity person works so hard."

The activities co-ordinator had circulated a questionnaire, seeking people's views and ideas about what they may be interested in. From the responses received, they had devised an activities programme. A monthly newsletter was produced by the activity coordinator, which people told us they enjoyed reading. Activities on offer included baking, sewing, bingo, action games, afternoon teas with a 'riddle' game, woodwork, rug making. Outside entertainers came regularly which people told us they enjoyed. We also saw many examples of community activities. Some people said they particularly enjoyed the visits to various public houses for a drink and a meal. During the previous summer there had also been trips out and staff were currently planning a series of barge trips for the summer.

However, a staff member told us there were less activities provided to people on the Elizabeth unit since the number of activities co-ordinators had reduced from two to one. A relative of someone who lived on the Elizabeth unit told us, "I've complained that there is not enough in terms of activities at the residents' meeting. The response was that they tend to go to sleep in the afternoon."

Inadequate

Is the service well-led?

Our findings

Relatives told us the registered manager and provider were not a visible presence around the home. One person told us, "I don't know who is in charge," and another commented, "I don't know the manager's name but (staff member) is great." Some people and their relatives expressed concerns about the management of the service. Comments included, "I am fed up of the attitude in the management; it's like no one is listening to us", "This home is not 'well run'. I am just so worried about my (relative's) future." Another relative expressed concerns about the attitude of one of the providers after they reported an incident, saying, "I've never met the owner but I spoke to them when (relative) escaped and (provider) said, 'if you don't like it, move home'." We were also concerned about some people and relatives who told us they were afraid to express concerns to the management team. Other relatives told us they did not feel welcomed by the management team and one person said, "They (the management team) will be friendly with you today; it's so obvious," and, "They are only being nice and friendly today because you are here." This reflected the lack of an open and transparent culture at the service.

Staff provided mixed feedback about staff morale, the culture and the approachability and effectiveness of management. One staff member commented, "Registered manager does understand what it is like to be a carer and is trying her best. I would say she is approachable." However they went on to say that staffing issues had not yet been fully sorted. Other staff told us the registered manager was approachable and the team worked well together. Another commented, "I think we have a great staff team; we help each other" and a third said, "There's a good vibe here. Everyone gets on. The teamwork appears to be quite nice."

However, other staff comments included, "It worries us all about the management attitude towards us", "Communication could be better from the registered manager, they should be more approachable", "I don't really know the manager; she has not made herself known", "We rarely see (the registered manager); we don't get any praise", "I have worked here for over a year; today is the first time the owner has ever spoken to me; it's because you and your colleagues are here", "Staff morale is so low", "There is something wrong with the management here; I don't think I could go to the manager with a problem anymore," and, "There are a number of staff that are frightened to complain."

We spoke with the registered manager about the concerns raised about their approachability and visibility. They said they were spending more time in the office than the previous manager due to working on improving systems and processes.

Incidents and accidents were reviewed at the end of each month by the registered manager and analysed to look for any themes and trends, for example, individuals involved, time and location of falls. A report was completed by the registered manager to confirm these areas had been reviewed. We saw there had been 37 falls in June 2017, with 35 of these on the residential unit. We were concerned with the high number of falls and identified a lack of information about incident and preventative measures in place. This indicated these reviews and actions taken were not sufficiently robust.

The registered manager undertook a range of audits and checks. For example, monthly audits took place in

areas such as incidents, care plans, medicines management, the environment and infection control. We saw these checks had been effective in identifying some issues and flagging up with staff to rectify. However we found these systems were not sufficiently robust as they had not prevented some of the shortfalls we identified from occurring. For example, systems should have been operated to prevent care plans becoming outdated, to ensure fluid charts were subject to regular review and to ensure covert medicines were only given following a robust best interest process.

Call bell response times were periodically audited. For example in March 2017 the registered manager had pressed the buzzer 10 times and the average response time during the day was three minutes 53 seconds. In June 2017 this had worsened to seven minutes and 35 seconds. We concluded from this and our review of call bell logs that these still were not being answered in a timely manner and actions from the audit had failed to address these issues.

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

Staff meetings were held monthly and we saw these were an opportunity for quality issues including the findings of audits to be discussed with staff to drive improvement.

People had opportunities to provide feedback on the service. Quarterly relative and resident meetings were held where a range of topics were discussed. Annual satisfaction surveys were also sent out to people and relatives. We looked at the results of the 2016 survey which were displayed in the reception area and showed what action was taken to act on people's negative comments.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care A complete assessment of people's needs was not always carried out. Regulation 9 (1) (2)(a)(b), Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 being provided in a safe way. The service did not always administer medicines in a proper and safe manner. Regulation 12(2)(b)(e)(g) Health and Social Care Act 2008 (Regulated Activities) Regulations

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 of service users was not always met. Regulation 14(1)(2)(4)(a)(d), Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess and monitor the quality of the service were not sufficiently robust. Regulation 17(1)(2)(a) (b) (c)(e) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

Issue warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's care and treatment needs. Regulation 18(1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

Issue warning notice