CCA & Mrs C Bolland

Laurel Bank

Inspection report

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20 March 2017

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 7 and 10 February 2017 and found breaches of regulation.

On 17 March 2017 we received information of concern following visits made to the service by the Clinical Commissioning Group (CCG). The concerns related to risk management in terms of monitoring people's weights, ensuring adequate nutrition and hydration and people being nursed continually in bed when there was no clinical reason why they could not get up. As a result we undertook a focused inspection to look into these concerns. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Laurel Bank on our website at www.cqc.org.uk.

We inspected the service on 20 March 2017. The inspection was unannounced.

Laurel Bank provides accommodation and nursing care for up to 37 older people. The property is a converted house which has been extended. Accommodation is spread over two floors and includes single and shared rooms. There are a variety of communal areas including lounges, a dining room and an enclosed garden. There were 24 people using the service when we visited.

The home has a registered manager who has been in post for many years. 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.

Many of the issues we identified at the inspection as detailed below, were raised at our inspection in February 2017 and have not been resolved by the provider.

We found people's nutritional needs were not being met. Records showed people had lost significant amounts of weight or had been of very low weight for several months, yet no action had been taken by nursing staff to explore this and steps had not been taken to boost people's calorie intake to help them gain weight. There was no evidence to show weighing equipment had been calibrated to make sure it was recording accurately. The last calibration date for one set of scales was 2013. Although the CCG had identified issues with the weighing scales and had asked for people to be re-weighed, we saw only 16 out of 24 people had been re-weighed.

Food and fluid charts were poorly completed, there was no evidence to show people were receiving regular snacks. Where people were having their fluid intake monitored there was no record to show the daily target intake and when we asked staff how much fluid people should be having they said they didn't know. There was no evidence to show nurses were reviewing the food and fluid charts and the deputy manager acknowledged this wasn't done. We saw charts which showed people had received very little to eat and

drink, yet this had not been picked up or acted upon by the nursing staff. We saw some people were being nursed in bed and were not getting up on a regular basis.

Some people were having thickening agents added to their drinks. For two people the thickeners were not prescribed on the MARs. There was not always information recorded to show how much thickener people should be having in their drinks and when we asked staff they were not clear with some telling us everybody had one scoop per 200mls and others said they gave two scoops per 200mls.

We saw Personal Emergency Evacuation Plans (PEEPs) had not been updated and some people had changed rooms and this was not reflected in the PEEP. This meant in an emergency the fire brigade would not have the correct information if they needed to evacuate people. We found weekly fire alarm tests had not been completed since 1 March 2017.

There were ongoing problems with the hot water supply and many bedrooms had no hot water. Staff told us they had to fetch hot water from the kitchen to take to people's bedrooms so people could have a wash. Although plumbers were on site trying to fix this issue staff we spoke with said there had been problems with the hot water for a long time. In one occupied bedroom we found there was a leak from the ceiling into the room.

Following the inspection a safeguarding meeting took place with the provider and an immediate protection plan was agreed and enacted which ensured people in the home were safe and received the care they required.

The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

The overall rating for this service is 'Inadequate' and the service remains 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.

We found that action had not been taken to improve people's safety. Risk to people's health, safety and wellbeing had not been assessed, monitored or mitigated in relation to nutrition, weight loss, pressure area care, medicines and aspects of the environment

Laurel Bank

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.

This focussed inspection took place on 20 March 2017 and was unannounced. The inspection was carried out by three inspectors. The team inspected the service against one of the five questions we ask about services: is the service safe. This is because we had received information of concern which related to the safety of the service.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and the clinical commissioning group (CCG).

We spoke with four people who were living at the home, two relatives, three care workers, the kitchen assistant, a nurse, the deputy manager, the registered manager and the provider.

We looked at ten people's care records, medicine records and records relating to the management of the service. We looked round the building and saw people's bedrooms and the communal areas.

Inadequate

Is the service safe?

Our findings

At our last inspection in February 2017 we identified a number of concerns around risk management in relation to individuals. This included how people's weight and nutritional needs were being monitored to ensure they were receiving sufficient amounts to eat and drink. Recent reviews undertaken by nurses from the clinical commissioning group (CCG) identified further concerns which indicated action had not been taken to resolve the issues.

At this inspection we found people remained at risk of malnutrition as there were not effective systems in place to monitor people's weights or to ensure that they were getting enough to eat and drink. We saw people who were low weight and had a low body mass index of below 18, which placed people at significant risk of serious health problems. We found weight records could not be relied on and were often inaccurate. This had been identified at the CCG visits and some people had been re-weighed when the CCG had asked for this to be done. However, we found no further action had been taken since then to check the remaining people's weight some of whose records indicated they were very low weight or had experienced significant weight loss. For example, one person's records showed they had lost 7.9kgs in six days. When we questioned this staff re-weighed the person and found this weight was inaccurate and there had been a loss of 4.3kgs over a four week period. Another person's weight records showed they were 36kgs on 8 February 2017 and had a BMI of 17 and they had not been weighed since. We found nurses were not identifying these discrepancies or taking action when records suggested people had lost significant amounts of weight.

The CCG had identified staff were weighing people on three different types of weighing equipment – stand on scales, chair scales and hoist scales – and there was no information to show which device was suitable to be used for each person. We found the same issues at our inspection and when we asked staff which weighing device they should use they did not know. The chair scales had been broken when the CCG had visited and the registered manager had arranged for chair scales to be brought across from the provider's other home. We looked at these scales which showed the last time they were calibrated was in 2013. Despite phone calls to the other home and discussions with the provider, the registered manager was unable to provide us with any evidence to show the scales had been re-calibrated since 2013. We asked to see the hoist weighing device but the deputy manager was unable to find it.

We had identified at our last inspection that food and fluid charts were poorly completed with no daily totals and no targets specified for recommended daily fluid intake. The CCG had found the same situation at their visits and reiterated the need for this to be recorded so staff could be assured people were receiving sufficient quantities to eat and drink. We found improvements had not been made at this inspection. Food and fluid charts were incomplete, there were no fluid targets and there was no evidence to show the charts had been reviewed by senior staff or that action had been taken when intake was low. There was no evidence to show people received regular snacks between meals. We asked staff if they knew how much fluid people should have and they said they did not know and were not told this information. One person who was low weight and nursed in bed told us they were 'very hungry' and said they would like a warm drink and something to eat. When we asked a staff member to bring them some food and drink they told us this person had already had some breakfast and a drink. We saw the staff member conveyed our request to the

registered manager yet 35 minutes later the person had still not received anything and it was only when we spoke directly to the registered manager that they arranged for staff to take the person the drink and food they had requested.

We saw some people who were low weight were on pressure relieving mattresses as they had been assessed as being at high risk of developing pressure ulcers. There was no information in people's care plans to show the correct settings for the mattresses which should be adjusted according to people's weights. We found mattresses were not set correctly. For example, the mattress for one person was set to 60kgs, yet the person's records showed they weighed 38.1kgs. If the wrong setting is used the therapeutic value of the mattress is affected.

We saw Personal Emergency Evacuation Plans (PEEPs) in people's bedrooms and in their care files which gave staff information about what action to take in an emergency. A checklist at the front of the care files showed the PEEPs were supposed to be updated weekly, yet none of the PEEPs had been updated since 1 March 2017. We saw some people had changed rooms and this was not reflected in the PEEPs. Two other people had moved rooms and there PEEPs had not been updated. This meant in an emergency the fire brigade would not have the correct information if they needed to evacuate people. We found weekly fire alarm tests had not been completed since 1 March 2017.

At our last inspection we found medicines were not managed safely. At this inspection concerns remained. We found where people were prescribed thickening agents these were not always prescribed on the medicine administration records (MAR). For example, staff told us one person was having thickener added to their drinks yet this was not prescribed on the MAR and the tin of thickener in the person's room was prescribed for another person. There was not always information to show how much thickener each person should have in their drinks. One staff member told us all those who had thickener had one scoop per 200mls, two other staff told us it was two scoops and there was nothing in people's care records or on the MAR to clarify the amount.

We looked at the MAR for a person who had been admitted for respite care. The MAR was handwritten and had not been signed by the staff member who completed it or counter-signed by another staff member. We saw prescribed nutritional supplements the person was taking were not included on the MAR. The deputy manager told us the person had brought their medicines in with them from home. We asked if any checks had been made with the person's GP to ensure that these medicines were current and they said no. The registered manager told us this person's condition had deteriorated dramatically since their previous admission. Yet despite this there were no risk assessments in place and only one care plan which related to catheter care. This meant there was no information to guide staff about the care and support the person needed.

We saw the dose of medicine on another person's MAR had been increased. There was no record to show when the dosage had increased or who had authorised this change and when we asked one of the nurses they were not able to provide this information.

We concluded all the evidence above demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations

At our previous inspection we identified problems with the hot water supply as the temperature from some outlets was only lukewarm. At this inspection we checked all the rooms and found 16 rooms had no hot water. We saw water temperature checks had not been carried out since 15 January 2017. Staff told us they had to get hot water from the kitchen to wash people. This was confirmed by one person we spoke with who

had a bedroom upstairs. They told us they had to come down in the lift and staff got them a jug of hot water from the kitchen so they could take it back up to their bedroom to wash themselves. There was a shower on the ground floor, which did not work. We spoke with one person who told us they did not like to have a bath but liked a shower. There was no other shower facility in the building. Plumbers were on site on the day of the inspection but told us they were having difficulty resolving the problem with the hot water. Staff told us the problems with the hot water had 'been going on for the last couple of months'.

We saw checks for legionella were last carried out in 2012. The provider told us there were no hot water tanks and stated engineers had confirmed that the water was heated by the boilers to a temperature which was high enough to ensure there was no risk of legionella.

In one occupied room where people were in bed there was a leak from the ceiling and we saw water dripping onto the carpet. There were marks on the wall and ceiling which indicated previous water damage. We reported this to the deputy manager who informed the provider.

We concluded the evidence above demonstrated a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations