SHC Rapkyns Group Limited

The Laurels

Inspection report

Guildford Road
Broadbridge Heath
Horsham
West Sussex
RH12 3PQ

Tel: 01403220770

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Laurels is a nursing home providing personal care and accommodation for up to 41 people with learning disabilities, physical disabilities and complex needs. The Laurels originally had four lodges but two are closed and people currently lived in two lodges called Juniper and Cherry. At the time of the inspection there were 12 people living at The Laurels.

The Laurels is owned and operated by the provider Sussex Healthcare. Services operated by the provider had been subject to a period of increased monitoring and support by local authority commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. The investigation is on-going, and no conclusions have yet been reached.

The service was registered before the 'Registering the Right Support' guidelines were in place. However, the service was not operating in line with the values that underpin the 'Registering the Right Support' and other best practice guidance. These values include choice, promotion of independence and inclusion. These values were not always seen consistently in practice at the service. For example, some people were not being supported to be as independent as they could be with activities or communication, and some were not receiving the assistance with communication they needed to be as independent as possible.

People's experience of using this service and what we found
People's relatives gave universally positive feedback about the service. Comments such as, "We are extremely happy with all aspects of [name's] care and couldn't wish for more. We chose The Laurels for the facilities, the care given, the spacious accommodation, and the stimulation a larger home provides."

However, our inspection found that sufficient improvements had not been made in a number of key areas. This was the sixth consecutive inspection where a breach of regulation concerning safe care and treatment was found. People were not consistently kept safe from risks around epilepsy, constipation and medicines. Not all lessons had consistently been learned and we found some issues with medicines errors and behaviour management.

There was a gap in training for agency staff and the competency of agency nurses was not checked. There was a risk that people would not have their healthcare needs met and we found issues with turning charts, and constipation risk management. There remained conflicting information between different care documents which demonstrated a lack of clarity about the care that was delivered to people.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Some decisions made on behalf of people didn't involve them and some DoLS conditions may not have been met.

Some people were not supported with their communication needs in the way they were assessed. This left them at risk of not being able to be involved in their care.

Care plans did not have goals or aspirations and were not person centred. People were going out more often, but more improvement was required around in-house activities to evidence people's involvement and link to their goals and aspirations.

The governance and auditing of The Laurels was not well led as audits had not been effective in putting right issues we found at the last inspection. This is the eighth consecutive inspection where governance and audits had not identified shortfalls. There was a new manager at the service who was registering with CQC and was working to change the culture in the service.

Staffing levels appeared to be safe from our observations and staffing levels on the rota matched the dependency tool. The service was clean and there was an infection control audit and champion, and staff used personal protective equipment to keep people safe from the risk of infection.

People had enough food and drink to maintain their health. Fluid charts had been completed accurately and peoples recommended daily amounts were met. People would receive joined up support if they moved from or to the service.

Staff and people were being more involved in the running of the service. The management had a vision for the service based around people having control of their lives. There was a culture change underway and the service felt happier and less hectic. Changes made to the service, such as people answering their own doors, was progress towards more person-centred support.
For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Inadequate (published 17 May 2019) and there were multiple breaches of regulation.

This service has been in Special Measures since April 2018

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Enforcement

We have identified breaches in relation to person centred care, dignity, mental capacity, safe care and treatment, staffing, and governance. One breach around dignity had been met but there were continued breaches of five areas since the previous inspection and one new breach around consent.

On 26 May 2020 we imposed conditions on the provider's registration telling them how they must act to address serious concerns regarding unsafe care for people with known risks associated with their support needs regarding epilepsy, constipation, behaviours that may challenge, nutrition and hydration, choking and aspiration and monitoring and acting in response to people's deteriorating health. The condition requires the provider to submit a monthly report to the Commission on their actions to improve in these areas.

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service

operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We also imposed conditions on this location regarding the restriction of new admissions and ensuring an external pharmacy audit is completed every month. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

The Laurels

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out on day one by two inspectors, a medicines inspector, and a nurse who specialised in learning disabilities. The inspection was carried out on days two and three by two inspectors.

Service and service type
The Laurels is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a registered manager in day to day control of the service. The registered manager was still registered as a manager with the Care Quality Commission, but they had left both the service and the provider in June 2019 and were no longer managing the service. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. A new manager had started in August 2019 and was applying to be registered with the Care Quality Commission.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority safeguarding team and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan

to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service and seven relatives about their experience of the care provided. We used observations and spent time with people as they received support. We spoke with nine members of staff including the provider, deputy manager, nurses, care workers and the chef. We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. We reviewed a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We received information from the provider and continued to seek clarification to validate the evidence we found. We looked at training data and quality assurance records. We spoke via the telephone with two professionals who regularly visited the service.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management, and using medicines safely

At our last five inspections we found a breach of regulation 12, relating to the safe management of risks. There were concerns with the safe management of medicines at the last five inspections and these concerns remain at this inspection. There were concerns with risks around people's health needs and learning from incidents at the previous three inspections and these concerns were found at this inspection. We found that insufficient action had been taken and the breach had still not been met.

- Some risks had not been managed safely. One person had epilepsy and experienced regular seizures. The person sometimes needed rescue medicine to be administered to help recover from seizures. There was a protocol for how and when to give the rescue medicine. It stated the person should have it after 10 minutes of one seizure, or cluster seizures (seizures one after another) and not to give a second dose.
- However, we found contradictory guidance stating that the person needed their rescue medicine after five minutes of a seizure or cluster seizures, and for an ambulance to be called if the seizure continued. This left the person at risk of not receiving the safe care they needed when they had a prolonged seizure or a cluster of seizures as nurses could not know when to give the rescue medicine. We raised this with the provider who amended the care plan. However, the person was put at risk due to conflicting guidance that the provider had not proactively identified before the inspection team pointed it out.
- In addition, there was no guidance on how long staff would wait before calling an ambulance. The epilepsy protocol also stated the person's oxygen level should be monitored and oxygen given until they obtain their baseline but failed to state what the baseline for oxygen was.
- This person had experienced a seizure in the week before our inspection. Their nursing notes recorded that the seizure had lasted four minutes and that their rescue medicine had been given. This was not in line with the protocol which stated it should be given after 10 minutes. If PRN protocols are not followed there is a risk that the person could receive too much or too little medicine.
- The persons' medicines administration record (MAR) had not been completed to show that the rescue medicine was given. An epilepsy recording chart and an epilepsy recording questionnaire had also not been completed for this seizure or for a subsequent seizure two days later. This left the person at risk of receiving too much of their rescue medicine if they experienced another seizure as staff may not know the person had already had a dose.
- We raised this with the deputy manager and operations director who confirmed the rescue medicine should be given after a 10-minute seizure. We were told that the seizure recorded as 4 minutes was in fact a cluster of seizures. However, it was not recorded as a cluster of seizures and staff acknowledged that there was no clear definition in the person's care documents as to what a cluster of seizures was.
- Not all staff we spoke with were confident in identifying different types of seizures. Some agency and four permanent staff had not had epilepsy training that included seizure management. One regular agency staff

working on a lodge with people with epilepsy told us, "I wouldn't know what to do if saw someone having an epileptic seizure, once I have had training I would be more confident to jump in there."

● Some people were not being supported as safely as possible during mealtimes. We observed one agency staff member supporting a person to eat and drink without following their speech and language guidelines. The person was given food and drink quickly throughout their meal and was not given time to swallow food before being given the next mouthful. They repeatedly coughed and showed some signs of distress. This was not recognised by the staff member.

● We raised this concern with a peripatetic manager who took actions including assessing the person's swallow, increased monitoring of the person's well-being, and reported to the local authority as an incident for review by their duty social work team.

● Another person had a nutrition care plan and 'eating and drinking guidelines' in place. The guidelines were written by a speech and language therapist employed by the provider and were referenced in the nutrition care plan. Both documents were in a written format and kept in the person's care plan folder in their room. Unlike other people living on the same lodge, the person did not have clearly identified guidance in the dining room and used during mealtimes for staff to help ensure staff knew how to support people as safely as possible. We asked the peripatetic manager why this was, as it had been identified following a safeguarding and speech and language review at the service following a serious choking incident in October 2018 that staff may not always know how to safely support people.

● We asked the peripatetic manager why this was, as it had been identified following a safeguarding and speech and language review at the service following a serious choking incident in October 2018 that staff may not always know how to safely support people. For example, placemats had been identified as a reasonable control measure to implement to manage this risk, especially given high use of agency staff who may not have time/access to care plan folders before supporting people.

● The peripatetic manager acknowledged that this was not something that had been considered. They phoned the NHS Speech and Language Therapist (SaLT) for advice and told us that they would now be developing their own placemats as the person was not currently under an active SaLT referral. They would also share these with the NHS SaLT for approval before using. This had not been proactively identified by the provider as a potential risk despite this being raised as a theme of concern at the service.

● People living with a learning disability can be prone to bowel problems such as constipation. The Laurels used elimination care plans to help people manage their bowel conditions.

● One person was diagnosed with constipation. They had two different 'as required' (PRN) medicines to assist with the relief of constipation. There were protocols written for when and how the person should receive these PRN medicines. However, the person's elimination care plan only referenced one PRN and not the two they were prescribed. The protocol stated that the first type of PRN was to be given after 2 days without a bowel movement. However, it also said it should be given after three days without a bowel movement which was contradictory.

● It directed staff to give the first type of PRN for two consecutive days before giving the second type of PRN. When we checked the care records the person had only had the first type of PRN for one day before the second type of PRN was administered. In addition to this, the protocol for the second type of PRN stated it should be administered once, with a gap of three days between the doses and two doses per week. However, this PRN was given on consecutive days and three doses were administered in a six-day period.

● Furthermore, whilst the first and second doses were being administered the first type of PRN had not been given for two days. This meant that the person was not receiving as much constipation medicine as possible to relieve their symptoms. The person eventually went seven days without opening their bowels and had to have a special prescription to help them.

● We raised this with the deputy manager who agreed that the protocol had not been followed but said there was a clinical reason for giving the second type of PRN after one day of the first PRN, and on consecutive days. However, there was no explanation as to why the first type of PRN was not given for two

days.
● We raised the failure to give PRN constipation relief as prescribed for two days as a safeguarding alert with the local safeguarding adults team.
● Some people living at The Laurels had behaviours that may challenge others, but not all these behaviours were being managed as safely as possible.
● One person had a 'mental wellbeing care plan'. The plan referred to behaviours that could be directed towards the person's self, their staff and to others. However, there was no positive behaviour support (PBS) plan for this. A PBS plan is a document that examines the reason for people's behaviours, and explains the help they need before, during and after an incident of behaviour that challenges other people. By not having a PBS plan staff would not be aware of how to support the person when they were challenging and would not be giving consistent support, which is key for people with behavioural needs.
● An incident had occurred in the week before our inspection where the person sustained a cut and had hit a staff member. However, there was no incident report or behaviour recording form completed. The last behaviour recording form completed was dated February 2019.
● We discussed this with the provider's autism and PBS lead and were told, "I would expect a behaviour form and incident form [to be completed] and then I'd come in and put strategies in place to avoid it happening [again]". The failure to record meant that no analysis of the behaviour could have taken place to help prevent a reoccurrence.
● Another person was known to display behaviours that may challenge others and could cause physical injuries to people and staff. The information in their care passport did not include information about the known function of these behaviours.
● Although there were suggestions about how to support the person that included staff reassuring them, forms of seclusion and isolation were suggested as the first preventative and reactive strategies.
● There was no guidance as to how to offer the person support as safely as possible. For example, how long to leave them alone, and how to ensure they were not unnecessarily isolated.
● The person had a known trigger around receiving personal care but there was no information on how exactly to support them with their personal care to minimise distress and anxiety that may lead to behaviours that challenge others.
● We spoke with the providers' autism and PBS lead about the lack of a PBS plan for this person, given their physically challenging behaviours. They told us that there had been a "basic" functional assessment and that a PBS plan was in progress. Staff were completing 'Antecedent-Behaviour-Consequence' (ABC) charts for when the person displayed behaviours that may challenge. ABC charts are a tool to record what happens before, during and after an episode of behaviours that may challenge. Staff had not consistently completed these forms in sufficient detail, so it was not always clear how the person had been supported and how effective this support had been in managing the behaviour. We looked at four ABC charts for this person and found a lack of detail about how long the incident lasted, whether any injury had occurred or what the staff did to resolve the incident.
● We found that the provider was not always managing medicines safely.
● Medicines, including controlled drugs (CDs) were store securely and were administered by registered nurses and care workers. However, systems did not provide assurance that refrigerated medicines were always stored at the manufacturers recommended temperature range. Staff did not act when the temperatures were out of range and the nurse on duty we spoke with did not understand how to use the thermometer. The impact of this was minimal due to the nature of the medicines being stored at the time of this inspection but this could pose a risk of future medicines stored not being effective due to the way they were stored.
● Systems for recording medicines audits and investigating medicines incidents did not always work consistently. The medicines audits did not always identify medicines concerns. For example, when doses were not signed for on the medicines administration chart (MAR), this was not always identified despite the

audit specifically asking about this.
● We found missing signatures on transdermal patch records as well as MAR charts. This was not picked up as part of the medicine's audits. Medicines incident reports were not always completed when there was an error identified. This meant that people were at risk of not receiving the correct medicine as transdermal patches are worn for a specific time, e.g. seven days, before being changed. Medicines audits had not been effective in ensuring that people received these medicines safely.

Learning lessons when things go wrong
● Not all lessons had consistently been learned when things had gone wrong. We found some issues with medicines errors where learning had not been implemented to reduce the risk of future errors.
● We found issues with behaviour management for people with behaviours that may challenge others. Some behaviours had not been recorded or reported which meant that lessons could not be learned from these incidents in order to improve outcomes for people.
● The safe management of risk was raised as a concern in our previous five inspections. However, we have found that the breach of regulation relating to risk remains at this inspection.
● The management of health needs such as epilepsy and constipation were issues we had found at other locations run by the provider. The same issues were found at this inspection showing that lessons had not been shared and embedded in to practice. There had been serious safety and safeguarding concerns raised about service users' care in these areas and the provider had failed to implement and sustain improvements to protect others who had similar health issues.
● The provider had not done all that was reasonably practical to assess and mitigate risks and provide safe care and treatment to service users, ensure safe and proper use of medicines and thoroughly review, investigate, monitor and make sure remedial actions and improvements are made in relation to incidents that affect the health safety and welfare of service users or have adequate arrangements to respond appropriately to people's changing healthcare needs. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Not all people were being kept safe from abuse. During this inspection we raised a safeguarding alert for one person who did not receive their medicines in the way set out in their protocol and did not receive certain medicines when they needed them. This placed them at risk of worsening bowel health from prolonged constipation. This had not been proactively identified or reported by the service before our inspection highlighted it.
● At our last inspection in March 2019 we made a recommendation about providing people with information about safeguarding in accessible format. At this inspection we found this had been done.
● The provider was using a safeguarding tracker to monitor incidents reported to the local safeguarding team. There was one open safeguarding alert which was being reviewed with the local authority. There had been a reduction in safeguarding concerns and most alerts that had been raised had been closed.
● There was an up to date policy with relevant legislation and links to other policies and documents. Updates around safeguarding were shared with managers and staff by the provider. A recent change in policy and online reporting form the local authority was placed in a bulletin and given to staff to read and sign for so they were aware of the correct reporting procedures.

Staffing and recruitment
● There were enough staff deployed to keep people safe and meet their needs. However, we have raised in this domain and other domains in this report concerns about the skills, knowledge and competencies of staff deployed.
● People and their relatives told us there were enough staff. One relative said, "There are enough staff with

the number of residents they have, and we tend to visit at the weekend." One staff member told us, "It's the same staffing levels, and everyone has two to one allocated by shift leader; it works well."
● We observed that people had enough staff to help them and did not see people waiting long to be supported if they needed something.

Preventing and controlling infection
● There was an infection control champion at the service in line with national guidance for this type of care home.
● Regular infection control audits had taken place. Action points from up audits had been followed up, such as an agency staff having inappropriate nails for work.
● We saw that the service was clean and free from the risk of infection. All the relatives and people we spoke with commented on the effective cleaning schedule in the service. One relative told us, ""It is always fresh and smells clean, there's no problems with cleanliness at all."
● Staff used personal protective equipment when required and the service was cleaned regularly.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At the last two inspections that this key question was inspected we found concerns relating to staff training and a lack of a holistic training process. At this inspection we found that improvements in these areas had not been made. We also found that there were concerns relating to consent and the rating remains Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- At our last two inspections we found a breach of regulation 9, relating to a lack of a holistic assessment process and people's social and psychological needs not always being considered in enough detail. The lack of personalised detail at initial assessment stage led to care plans being high level and lacking detail around social needs. At this inspection we found insufficient action had been taken and the breach had still not been met.
- There had not been sufficient progress in re-assessing people's social and psychological needs. These were not being considered in detail when planning and delivering support. This increased the risk that people's preferred outcomes would not be identified or achieved.
- We spoke with the provider's autism and positive behaviour support (PBS) lead about the lack of plans around functional assessments for some people and were told that some people who had these plans had moved on. The PBS lead also told us, "We've developed a PBS course running since April. We've also called BILD [British Institute of Learning Disabilities] in to help upskill staff and have done an initial gathering process and made suggestions as to how they can help us as an organisation. It's about upskilling people and we will be starting that in September." However, this remained an area that had not had sufficient action to demonstrate improvements.

The failure to assess and design care and treatment with a view to achieving service user's preferences and ensuring their needs are met was a continued breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- At our last two inspections we found a breach of regulation 18 relating to training and competence of staff. At this inspection we found insufficient action had been taken and the breach had still not been met.
- There was a gap in staff training and competence for agency staff. The service used a high number of agency nurses and carers to fill shifts as there were vacancies in permanent staff roles. However, the provider was unable to demonstrate how the training and competencies of these staff had been checked prior to working at The Laurels to ensure they were competent and safe to work with people.
- The night time nurses working at The Laurels were all agency nurses. We asked the deputy manager about how they supervised these staff and how they assured themselves that the staff were trained and

competent. The deputy manager told us, "That is an ongoing task for me to implement. They get comprehensive handover on shift. I am working on ways to get nurses competencies assessed." Agency Night staff were not receiving supervision which meant that they may not have access to management to formally discuss any concerns or have their clinical practice audited. This is a particular risk as there were no permanent nurses or managers working night shifts.

● There were some areas of clinical practice where agency nurses' competencies were not demonstrated, for example oral suctioning. Oral suctioning is the use of a suction tube to remove secretions through the mouth. We requested to see nurses training files or agency profiles but there was no evidence that nurses were competent to perform this clinical task. Some people at The Laurels required oral suctioning to clear their airways at certain times. Without specific training and clinical supervision, the provider could not demonstrate that nurses had the competencies for this specific task. Failure to competently and consistently carry out oral suctioning for people could place people at risk of choking or developing chest infections from breathing in secretions.

● There were some gaps in training and knowledge in the staff team, for example around managing behaviours that may challenge. We spoke with one staff member who told us they had not had training around managing people's behaviours. When asked how they managed one person's behaviours they told us, "Just manage best you can, follow protocol keep distance or you will get scratched. Go in with long sleeves on and be assertive." However, the lack of training and management of behaviours created an inconsistent approach to managing people's behaviours, which can make some behaviours worse.

● Permanent staff told us that some agency staff lacked the required skills. One staff said, "Agency staff did not always have the right skills and experience, impacts a lot have to do most of it yourself. Can impact on people who live here, might refuse support, have raised with manager they have a list of good agency [staff] so they are rebooked."

The failure to provide staff with the training and support they needed to be effective in their roles was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● There were various MCA assessments completed for restraints or restrictions placed on people for their safety. This includes the use of bed rails, for turning repositioning, using sleep system and the use of lap strap. The assessments completed determined the person lacked capacity to make decisions in these areas, but there was no evidence of a best interest meeting or decision. One staff member had written the MCA assessments, but there was no other opinion sought to determine if those decisions were in the person's best interest and respected the person's wishes.

● Some staff did not demonstrate a sound understanding of the Mental Capacity Act principles and advised they would refer to care plans or ask for advice if they were unsure. Some staff did not know what a DoLS was and were not aware of the specific conditions applied to people's DoLS. One person's keyworker and

senior care worker were aware of what a DoLS was but not of the specific conditions that made that person's restrictions lawful.

● One person had a DoLS condition that stated they be taken out for activities, including into a town setting twice a week. We checked records for an 11-week period between June and August 2019 and this was not happening. The condition was made as regular outings were important to the person in their previous care home. If staff were not taking the person out as frequently as they were supposed to this could negatively impact the persons wellbeing and lead to a sense of isolation.

● Following a recent safeguarding, there had been a specific recommendation that a separate MCA and best interest decision be carried out in relation to an historical decision made by staff on behalf of a person not to have a clinical test. We asked the deputy manager if this had been completed, as it was not evident in the person's care records. The deputy manager confirmed that this action was still to be taken.

The lack of consistent practice with regard to obtaining and documenting consent for care and support was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Supporting people to live healthier lives, access healthcare services and support

● People were at risk of not having their health needs met. One person required support to be turned every four hours at night time. We checked their turning charts and found they were regularly left for between seven and eight hours between turns. This placed them at risk of pressure areas and skin breakdown as the person was not able to turn independently.

● Another person had been assessed as at high risk of skin breakdown and pressure sore development, with a Waterlow score of 17. A Waterlow score gives an estimate for the risk of developing pressure wounds. A score of 17 indicates a 'high risk'. Their 'skin integrity care plan' and sleeping care plan both highlighted the need for four hourly incontinent pad changes. Daily care notes did not demonstrate that the person was receiving this support at night time and documentation was inconsistent as to when or how often their pad was changed in the daytime.

● We were then told by a peripatetic manager that these plans were out of date following a review with a bowel and bladder nurse. However, there were no notes of the review and no sign the plans had been reviewed with the updated information. It was not clear how this information had been shared with the staff team so that they were aware of the most up to date plan of care for this person.

● The same person had risks associated with constipation and was prescribed a PRN [as required] enema. The nurse on duty confirmed that there was no PRN protocol for the enema to direct staff on how it should be used.

● There was also different advice and inconsistent details in their constipation documents about how staff should support them to manage this risk. Their 'constipation' care plan and bowel monitoring charts stated different times for the PRN enema to be used, e.g. after two days or after three days without a bowel movement.

● Their medicines administration record (MAR) contained hand written administration details for the treatment of constipation whereas their 'elimination' care plan did not refer to them being at risk of constipation or how this risk should be managed. Due to the inconsistent information the person was at risk of not receiving effective support to manage their constipation. Having inconsistent information and guidance means staff may not give the correct treatment or give it too late. This is a particular risk due to the higher number of agency nurses working at The Laurels.

● The person's 'Care Passport' detailed the support they required including with medicine and continence needs. The sections relating to medicines did not mention prescription of PRN Enema. The section relating to medical interventions did not mention the possibility of administering an enema or how they may need support with this. This left the person at risk of not receiving their enema as prescribed and of suffering ill health with their bowels.

The failure to safely manage risks around health conditions was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Supporting people to eat and drink enough to maintain a balanced diet

● People had sufficient food and drink to maintain their health. For people who needed their fluid intake to be monitored for health reasons, their fluid charts had been completed accurately.

● Some people had recommended daily allowances (RDA's) of the amounts they should drink to ensure they were well hydrated. Where this was the case people's RDA's had been achieved.

● People and their relatives told us that they had enough food at The Laurels. One relative commented, "I usually visit on Sunday and [name] asks the chef to prepare meals for us and we eat together; there are days when they ask for different food to the menu. The food was tasty and nutritious." Another relative said, "I turn up unannounced and [name] has put on weight. The food is good."

Adapting service, design, decoration to meet people's needs

● The design of the building met people's needs. There were wide corridors able to accommodate people's wheelchairs comfortably. People's bedrooms were equipped with overhead hoists and had en-suite bathrooms with shower facilities. There was also a hydrotherapy pool. However, this had been out of use recently.

● There had been a change in the way the building was used. Visitors were re-directed to knock on the external door of the two lodges, as opposed to the internal connecting doors. People were supported to answer their own 'front door'.

● We spoke to the regional operations director about the changes and were told that each lodge would be individually approached. The aim was for people having control of their own front door.

● There was a family room and there were empty flats within staff accommodation that could be made ready for visiting relatives to use if needed, e.g., for summer BBQ's if they were travelling from distance.

Staff working with other agencies to provide consistent, effective, timely care.

● The deputy manager was able to describe the process for how they would work with other providers prior to any move to or from the service; including how new people would have their needs matched to staff skills and current people living at the service.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Requires Improvement. At the last two inspections that this key question was inspected we found concerns relating to people not being treated with dignity and not being supported to be as independent as possible. At this inspection we found the breach for dignity was met. However, we found a new breach relating to a lack of personalised communication.

Supporting people to express their views and be involved in making decisions about their care

- We previously found a breach of Regulation 10 and this has now been met at this inspection. Staff were treating people in a dignified way. One person told us, "Staff listen to me; make me happy and do what I ask them." We observed staff upholding people's dignity. We did not hear any task-based language or see staff talk over people.
- However, staff were not consistently supporting people with their preferred methods of communication. One person had agreed communication strategies for when they refused food, including the use of a picture exchange system and Makaton. A picture exchange system is a form of communication where people can choose pictures to give to staff to tell them what they want. Makaton is a form of sign language where signs are used with speech in spoken word order.
- The person's nutrition plan referred to the importance of staff using a picture exchange system and Makaton to help them make menu choices and encourage them to eat if refusing. However, neither the agency staff member or the peripatetic manager attempted to use the picture exchange system.
- The agency staff and peripatetic manager's manner and language was not always in line with the person's protocol. The support we observed was at times not very positive or personalised because the person's communication strategy was not used. Not much effort had been made to engage with the person when they refused food, including using their recognised communication preferences of picture exchange system and Makaton. The person's key worker, when asked to support them, was very positive and engaged them using Makaton, and was able to support them to eat. However, it was clear this approach was not consistently applied.
- Two care documents around communication for this person did not mention picture exchange and we did not see any staff using a picture exchange system with this person. We only saw their key worker using Makaton with them. This left the person at risk of not receiving the correct support the required around mealtimes and making their needs understood. This meant that the person was not being supported to be as independent as possible.
- We spoke with the provider's PBS lead who told us; "It is a work in progress getting staff to use a picture exchange system. They don't understand that it will help [name] to make choices". They told us they were running small workshops on communication but that much of this work was on-going and learning had yet to be embedded in staff practice.

The failure to ensure all people received personalised support with their communication was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity

● Relatives spoke positively about staff approaches to people and described staff as kind and caring. One relative told us, "I think they are caring and are very pleasant. The staff I speak to are very, very good. If [name] disagrees they will shout or jump in their chair and staff play their favourite song and they calm down; if they want something staff arrange it straight away."

● Another relative told us, "The Laurels is a happy home, we couldn't wish for better for [name]. A more friendly, caring staff would be hard to find."

● We observed that staff treated people kindly. One staff pretended to do an arm wrestle with a person and made a joke out of them winning 'best of three'. The person enjoyed this tactile interaction and the joke and appeared happy afterwards. Staff used this as a way of asking them to do the laundry. Staff spoke to people using kind language and spoke to people and asked their permission before moving people in their wheelchairs.

Respecting and promoting people's privacy, dignity and independence

● People's privacy was respected. One relative told us, "Privacy is always protected. When [name] needs changing they shut the door and close the curtains so there's no problem there. When nurses give [name] an injection they take her in to the nurses room or her room to be somewhere private."

● There was some work being done to increase people's independence. One person told us, "I can the answer door, but I can't move my wheelchair around."

● The regional operations director told us about plans to give people more freedom, "We want to try having people's money in their own room, so they don't have to come to staff to ask for their own money. We are waiting for sign off from social services."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At the last two inspections that this key question was inspected we found concerns relating to people not being supported in a personalised way including person centred care plans, and personalised activities that were meaningful to people. At this inspection we found there had not been sufficient improvement and this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- At our last two inspections we found a breach of regulation 9 relating to person centred care and people not receiving personalised care with activities and having personalised care plans. At this inspection we found insufficient action had been taken and the breach had still not been met.
- We received mixed evidence regarding how well staff knew people. Permanent and longer serving members of staff did appear to know people well and have a good relationship with them. There was a concern that agency and newer members of staff did not have this knowledge and the knowledge permanent staff had of people was not reflected in people's care records or in current care planning or assessment processes. This presented a possible risk that people may not be supported in a person-centred way.
- Although work had started to gain information about people's histories and preferences, there was a large variation in how far staff had been able to support this work with people to gather information regarding people's life history, preferences and likes and dislikes for non-clinical support needs. For example, one person's care plan we reviewed did not have any of this information available for staff and they were unable to tell staff fully themselves. This left the person at risk of being supported by agency staff who may not know their needs well.
- It was not always evident from people's care records and our observations that support was truly personalised, and that people had the best quality of life, or took part in activities that were meaningful. We observed some craft activities where people were mostly sat watching staff complete the craft tasks. One person was offered the chance to join in and refused and was left t sit and look around the room. People were doing the same activities week after week, with no evidence of analysis or learning, or that people were being supported to develop and achieve individually meaningful aspirations and goals, in line with their needs and choices, in any structured or measurable form.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider was not consistently meeting the accessible information standard (AIS). People had a one-page sheet in their care plans explaining what the AIS was and how it should be met. However, the actions

to meet the AIS had not been carried out consistently for people.
● For example, one person's AIS one-page sheet referred to using short sentences and clear words to present information. However, their communication plan stated they didn't use speech or signing. There was also limited information on the communication plan about how the person's vocalisations and body movements related to their communication. This meant staff may not be able to meet people's communication effectively. The lack of information around how to effectively communicate with the person meant that they were at risk of not having their communication needs met, particularly when being supported by agency or newer staff which happened frequently.
● There were gaps in staff training around communication. Out of 14 care assistants only seven had completed effective use of communication training and only four had completed Makaton training. Some people used Makaton to communicate their needs and not having staff who were consistently trained in this area impacted on people's ability to communicate with their staff as they did not have staff who could use Makaton effectively with them.
● Relatives told us that they thought staff communicated well with people. One relative told us, "[Name] has communication difficulties, however he makes himself understood by using sounds, gestures and eye-pointing. The staff are very good at understanding him and will persevere until he has got his needs across to them."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.
● The provider had completed some work to improve community access for people and there was an additional resource for improving driver availability. The activities co-ordinator had developed the schedule of available in-house activities for people living at the Laurels, to include more choice and variation on a day to day basis. The design of the sessions had also been improved to help ensure that activities were helping people achieve set aims, such as sensory awareness and spatial awareness. However, these aims were generic, and it was not always evident how these linked to individual needs and choices or level of ability.
● Group and individual activities at the service were still mainly delivered by the activities co-ordinator. There was also a part-time activities assistant. As long-term care staff who may know people's needs were not overseeing activities and care plans lacked person-centred detail, this impacted upon how personalised, and meaningful activities were, or how many different choices could be accommodated, as it meant there was just the activities co-ordinator or their assistant to deliver the group activities.
● The activity co-ordinator told us that care staff were starting to get more involved in coming to activity sessions and supporting people at the service directly, but they tended to come for a while and then leave due needing to support people with personal care needs. This left the activities lacking a personalised element for some people who required extra support to engage.
● There had been some work by the activities co-ordinator to develop guidelines to support activity staff to deliver activities in a group setting and how to record activity evaluation notes. The Engagement manager was taking the lead on using this data to develop more group and individual meaningful activity plans. However, they told us that designing individual and group activity schedules had been affected as the original "clinical assessment process" had neglected to gain relevant personalised holistic information about people's preferences and life histories.
● There were steps being made to make the service more personalised and to give people a sense of control of their environment. One person was being supported to conduct fire checks and another person was being supported to check the temperature of fridges in the service. This gave people a sense of ownership of their home.

The failure to provide person centred care was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Improving care quality in response to complaints or concerns

● There was an up to date complaints policy updated in February 2019. The service had recorded one complaint in the last 12 months, which was handled in line with the providers policy.

● The complaint was recorded on a complaint form and staff had followed up on the complaint. Staff documented how they involved the person and the former registered manager had arranged for staff to contact the family and update them.

● Compliments had also been recorded in the file. There were lots of compliments from relatives and other visitors about the cleanliness of the service and the effectiveness of the domestic team.

End of life care and support

● There was nobody receiving end of life care at The Laurels.

● People had been asked to complete a future care plan about their wishes in relation to their final days. One relative told us, "I had an email about end of life care planning, but I haven't done anything yet."

● We reviewed one person's care plan who had a funeral plan in place and it contained personalised information.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

● At our last seven inspections we have found a breach of regulation 17 relating to auditing the quality of the service. There were concerns with the governance, auditing and oversight from the provider including learning from previous incidents, and these concerns were found at this inspection. We found that insufficient action had been taken and the breach had still not been met.

● Quality audits had not been effective in putting right some of the issues highlighted at previous inspections, such as those relating to the safe management of risk or medicines. For example, there were four times daily medicines audits completed yet we found signatures missing for epilepsy medicines, yet the audit completed stated that the medicine had been singed for and given.

● Other audits were not effective. For example, there was a bowel management audit, but this had not highlighted concerns that people were not receiving their constipation medicines when they should have been. The audit prompted nurses to state whether there was information in place such as, a protocol for PRN laxatives, and not the quality of information included or whether there had been gaps or errors.

● There was a service improvement plan used to monitor progress in quality. However, areas marked as complete, such as ensuring that all care plans were updated as well as reviewed to evidence most up to date information, were areas found lacking at our inspection.

● An external consultant had audited the service on 1 July 2019 and found amongst other issues that support plans were variable in content and lacking in detail, MCA assessments were lacking best interest decisions and daily notes were task focused. We found these issues persisted at our inspection.

● Concerns about epilepsy management, constipation, safeguarding and fluid monitoring had been highlighted to the provider on a number of occasions at others of their services. This information had not been properly shared or used to improve safety and care at The Laurels.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● A safeguarding alert was sent to the local authority during the inspection by CQC as the provider had not sent this for a medicines incident where a person did not receive their PRN laxative as directed.

● There was not a registered manager in day to day control of the service. It is a requirement of the provider's registration for a registered manager to be in post. The previous registered manager had registered with CQC in March 2019 but had left the employment of the provider and not yet applied to re-register. We have raised this with the provider.

● The provider had initially based a peripatetic manager at the service to oversee day to day management. The manager had submitted an application in July 2019 to be registered with CQC. This was being

processed at the time of the inspection. There was a deputy manager who was also the clinical lead and still completed nursing shifts. The manager was not available during the course of the inspection.
● We imposed provider wide conditions on the providers registration that they must submit a monthly report to CQC analysing incidents, reporting any unplanned hospital admission and the steps taken to address staffing shortages and skills. We also imposed conditions on The Laurels in November 2018 regarding the restriction of new admissions and ensuring an external pharmacy audit is completed every month.
● Despite the provider wide condition and location specific condition we have not seen sufficient improvement in meeting the regulations. For example, the most recent medicines audit from 13 September 2019 continues to reference a lack of regular audits and genuine actions. Provider level governance of The Laurels, to ensure effective audits are carried out and shortfalls are corrected, remains poor.
● The deputy manager told us they had support and felt well supported by the provider. However, given the repeated breaches and the lack of permanent nursing staff there was a risk that there had been insufficient support for management. The failure to meet breaches over the past eight consecutive inspections meant the providers understanding of risk and regulatory requirement remained inadequate.

The failure to assess, monitor and improve the quality and safety of services, to mitigate risks, and to maintain accurate records, was a continued Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was a culture change underway within the service and management were starting to make changes to give people greater control over their lives. The deputy manager told us, "The culture is calm now as the staff believe in themselves and it is partly due to the support they get from management. They needed that support from management and for us to be able to come and help them with any task."
● The day to day culture in the service felt calmer than during previous inspections and was kept under review during daily walkarounds by the deputy manager and members of the management team. The deputy manager told us, "When I conduct nursing shifts I can see how shifts are being run and can see if things are not working well. I challenge any staff if they use inappropriate language with people or approach a person in a way that sounds rude."
● As part of the culture change the management team were implementing a more open and transparent culture for staff. Staff were kept up to date with management changes and there were phone numbers for staff to access assistance out of hours. The weekly communication from the provider to staff had a standing item for whistle blowing and safeguarding, with contact details and staff were encouraged to report concerns.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider and management team were aware of their responsibilities to report incidents under duty of candour.
● We discussed a recent incident where a person was injured. The deputy manager commented, "I was alerted by carers, did clinical judgment and acting manager did a report which was sent to quality, and we notified the local authority and CQC. We also told the family who were happy we were open and honest and had notified [them] within an hour."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were involved in monthly meetings to discuss any changes they wanted to make, such as around activities changing or setting up a new tea bar in the service. People were kept up to date regarding staff changes. When the registered manager left that was put across in a meeting with each person.
● The deputy manager described how people were involved in changes to the building's décor. They told us, "People are excited about choosing colours for the lounges. They are having a photo shoot on Cherry Lodge and having photos put on canvas for their lounges."
● Relatives were invited to family meetings every few months and were provided with details of any planned changes. One relative spoke to us about management and changes and commented, "I personally think they are making every effort to improve things and they tell us how they are getting on and I am happy with how things are improving."
● Staff had the opportunity to attend regular staff meetings. The deputy manager told us that staff are invited to come up with new ideas for activities. The deputy manager said, "Last Monday I got the whole of Cherry Lodge out for bowling and dinner afterwards. On Tuesday it was conducted for Juniper Lodge and was successful."

Working in partnership with others
● The management team were working with the local safeguarding team and had been meeting on a monthly basis until recently to close open safeguarding enquiries. Other professionals such as speech and language therapist and occupational therapists have all visited from the local health teams. There had also been regular meetings with the local CCG and social workers.
● The deputy manager told us, "We've been providing social workers and care managers, and CHC updated regarding our status with CQC and WSCC so they are familiar."
● Information was being shared securely with other agencies, using encryption. Unique identifiers were being used instead of people's names to protect people's identities.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had failed to assess and design care and treatment with a view to achieving service user's preferences and ensuring their needs are met. The provider had failed to support people in a person centred way with their communication needs. The provider had failed to provide person centred care.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider demonstrated a lack of consistent practice with regard to obtaining and documenting consent for care and support.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users, ensure safe and proper use of medicines and thoroughly review, investigate, monitor and make sure remedial actions and improvements are made in relation to incidents that affect the health safety and welfare of service users or have adequate arrangements to respond appropriately to people's changing healthcare needs.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of services, to mitigate risks, and to maintain accurate records.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to provide staff with the training and support they needed to be effective in their roles.

The enforcement action we took:

We imposed conditions on the provider's registration.