Mr & Mrs D Caley

Laurieston Care Home for the Elderly

Inspection report

Laurieston Care Home
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13 December 2021
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05 January 2022

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Laurieston Care Home for the Elderly is a residential care home providing accommodation and personal care to 12 people aged 65 and over at the time of the inspection. The service can support up to 16 people in one adapted building.

People's experience of using this service and what we found
People were not protected from abuse or avoidable harm. Risks to people were not always safely identified, assessed and managed. Care records were not always comprehensive or up to date and therefore did not accurately reflect people's needs. The provider failed to ensure there were enough suitably competent and skilled staff on duty to meet people's needs. Staff were not always recruited safely. Medicines were not safely managed, although regular stock checks were carried out and these records were accurate. Staff did not follow infection prevention and control procedures and had not completed up to date training in this area. PPE was not always worn correctly. The service was accessing COVID-19 testing in line with government guidance.

The service was not well-led. People did not always receive person-centred care and there was not a positive culture within the home. The provider failed to make improvements when things went wrong and the quality of the service had deteriorated since the previous inspection. Staff roles and responsibilities were not clear, and quality assurance measures were ineffective. The provider did not always comply with regulatory requirements. The service did not always engage appropriately with people, staff and professionals. We received mixed feedback from relatives about communication and atmosphere within the home. One relative told us, "I don't feel confident or comfortable speaking to anyone" whereas another relative told us, "It is friendly and homely." Referrals to healthcare professionals were not made in a timely manner, or at all, although the deputy manager had sought outside professional assistance before our inspection.

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 good (published 22 December 2018).

Why we inspected
We received concerns in relation to the way people using the service were being treated by the provider. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all

care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Laurieston Care Home for the Elderly on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to providing person-centred care, safeguarding service users from abuse and improper treatment, providing safe care and treatment, good governance, recruitment and staffing.

We have identified a breach in relation to the service's regulatory requirement to notify CQC of important incidents. This will be dealt with outside the inspection process.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 is therefore 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Laurieston Care Home for the Elderly

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Laurieston Care Home for the Elderly is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 had a manager in post who was in the process of registering with the Care Quality Commission. Once registered, they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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 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 two people who used the service and eight relatives about their experience of the care provided. We spoke with 12 members of staff including the provider, manager, deputy manager, activities co-ordinator, domestic staff, care staff and two ex-employees. We reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We liaised with, and obtained information from, the local authority, commissioning, safeguarding, the fire service and the infection control team.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from abuse or avoidable harm. The provider did not always treat people with dignity and respect.
- People had experienced emotional and psychological abuse. We became aware of a number of incidents where the provider had demonstrated inappropriate and controlling behaviour towards people, causing people to feel intimidated and frightened.
- Staff did not always recognise or respond appropriately to abuse. The provider failed to recognise and understand the impact of their behaviour on people. The provider failed to investigate concerns raised by staff and failed to raise safeguarding alerts when they had concerns themselves.

This failure to protect people from abuse and avoidable harm was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we made a number of referrals to the local authority safeguarding team. We have continued to work closely with the local authority and other relevant professionals to ensure the safety of people living at the service.

Assessing risk, safety monitoring and management

- Risks to people were not always safely identified, assessed and managed. There were significant gaps in people's care plans. We found care plans were missing for one person in respect of their continence needs, skin integrity, sleeping, health, wellbeing, cultural or spiritual needs, life history, breathing, personal safety, environmental safety, and call bell needs. This meant staff did not have sufficient information to safely support this person.
- People's care plans did not always meet their needs. We found one person was prone to depression, yet there was no care plan around this person's mood and mental health. This meant there was no information for staff about the impact of this condition on this person, the signs to look out for which could indicate a deterioration in this condition, and what it meant for this individual.
- Risk assessments were either not in place or were not up to date. The service used an assessment tool, to assess the risk of people developing pressure sores and wounds. We found these scores to be out of date, and they had not been reviewed when people's needs had changed. This placed people at risk of harm, as the scores did not reflect the actual risk to people.
- Where risks were identified, they were not always appropriately managed. One person suffered a serious choking incident. The provider told us this person had not been a known choking risk. However, their breathing care plan, dated three months prior to the choking incident, stated they were at risk of choking.

The breathing care plan had not been followed at the time of the incident.
● The provider failed to appropriately assess and manage environmental risks to people's safety. Fire drills were not completed. We found cleaning products which had been left unattended, and an exposed electrical socket on the wall in the dining room. The provider did not robustly check equipment such as sensor mats and electric stand aids, to ensure they were functioning and in good working order.

Risk was not effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider failed to ensure there were enough suitably competent and skilled staff on duty to meet people's needs.
● Staff did not always have the right training and competency to ensure people's care was managed as safely as possible. There were significant gaps in staff training across multiple areas including palliative care, continence care, catheter care, pressure areas, skin integrity, falls, GDPR, dementia, and diabetes. These gaps in training were not in line with best practice guidance, and did not demonstrate how staff had the necessary skills and knowledge to meet people's individual needs.
● There were not always sufficient staff on duty to safely care for people. The provider did not take into account each person's individual needs when calculating staffing levels. Two carers worked each night shift. At the time of the inspection the provider supported two people who required 2:1 support. When these people needed support on a night-time, there was no other carer to meet other people's needs.
● The provider did not regularly review staffing levels and the skill mix of staff, to ensure the service responded to people's changing needs. After our inspection feedback, the manager introduced a dependency tool to calculate appropriate staffing levels.

There were insufficient suitably trained staff employed by the provider. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Staff were not always recruited safely. Systems and processes were not in place to ensure suitable and appropriate staff were employed.
● Required recruitment checks on staff were not always made. The provider failed to obtain enhanced disclosure from the Disclosure and Barring Service (DBS). This meant staff were working at the service when the provider did not know if they were on the barred list for working with vulnerable adults.
● Recruitment information required by regulation was missing from staff files. This included records of interviews and complete employment histories for staff. There was limited evidence that suitable checks had been carried out to consider the suitability of prospective employees.

Systems were not in place to ensure staff were recruited safely. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not properly and safely managed.
● Where medicines were prescribed as 'when required', records were not completed to show why these medicines were given, or if they were effective. One person was administered 'when required' medicine on a routine basis. This had not been reviewed, and there was no process in place to highlight when a review was required.
● Systems were not in place to effectively monitor the application and use of pain relief patches. These patches should be rotated upon each application. However, the location of the patches was not recorded

and so it was not possible to know where the patches had previously been located. Patches were not rotated in line with guidance to reduce the risk of potential side effects for people.
● Creams and lotions were not always administered as prescribed. There were significant and unexplained gaps in medicine records for creams.
● Medicines were not stored safely and in line with best practice guidance. The provider told us that the temperature of the medicines room and fridge were checked daily. However, records could not be located for the fridge temperature after July 2021, and no records for the room temperature checks could be located.
● Medicines were not disposed of appropriately. We found prescription medicines belonging to a deceased service user in the manager's office. We also found out of date prescription medicine for a current service user in the manager's office. The provider was unable to tell us why these medicines were there, and why they had not been disposed of appropriately.

Medicines were not safely managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The night staff carried out a daily stock check and the stock counts we reviewed were accurate.

Preventing and controlling infection
● The provider did not always follow or meet national guidance in relation to infection control.
● PPE was not always worn appropriately. The owners did not always wear a mask or wear a mask appropriately. One staff member wore a visor instead of a mask, contrary to government guidance. This placed people at risk of COVID-19.
● Visitors were not robustly screened. There was no system in place for ensuring visiting professionals were appropriately vaccinated. After we fed this back to the service, the manager introduced documentation to record visiting professionals' vaccination status. However, professionals told us that staff still failed to seek appropriate assurances around vaccines.
● The environment did not support good infection control. Parts of the service were extremely cluttered. PPE had been stored in a container which also contained a urine bottle and used underwear. Personal toiletries and equipment were stored in communal bathrooms.
● Staff had not received infection control training since before the pandemic. However, the provider later told us two members of staff had attended a local authority presentation about COVID-19 and fed this back to the rest of the staff team. The provider also told us staff had completed online training in how to correctly put on and remove PPE.
● The provider's infection prevention and control policy was not up to date. Although the policy had been reviewed in January 2021, no changes had been made to reflect the pandemic and incorporate national guidance.

Infection control was not safely managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was accessing testing for people using the service and staff.

Learning lessons when things go wrong
● The provider failed to learn and make improvements when things went wrong. The quality of the service had deteriorated since the previous inspection.

● Safety concerns were not consistently identified or addressed quickly enough. One service user had left the service when it was unsafe for them to do so, and without staff being aware. The provider failed to identify the building security concerns and failed to take any action to increase security.
● There was no system to record accidents and incidents in a way which would enable analysis to be carried out, trends identified, or lessons learnt.
● The provider was slow to act on concerns we raised during the first day of our inspection on 13 December 2021. A number of concerns had not been addressed when we discussed them again with the provider on 5 January 2022.

This failure to learn lessons when things go wrong was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 good. At this inspection this key question has now deteriorated to inadequate. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The service was not well-led. The provider did not ensure that high quality and person-centred care was consistently delivered. During the inspection process, we were informed of a number of incidents where people did not receive person-centred care.
- People did not have their human rights upheld. The provider had failed to respect people's choices, wishes and preferences.
- Some staff told us leadership of the service was overbearing. Some staff did not feel listened to, respected, valued or supported. One staff member told us, "It's not a happy place at the moment." We did receive some positive feedback, but this was outweighed by the negative feedback. One staff member told us, "I have no problem with the owner, and I could go to the manager if I had any concerns."
- The provider displayed controlling behaviour towards both staff and people. Staff comments included, "[The provider] is around all the time, you feel like you're being watched" and "[The provider] will shout at staff in front of residents."

This failure to ensure systems were in place to provide person-centred care and promote a positive culture was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; continuous learning and improving care

- The provider was not always open and honest when things went wrong. The provider did not always inform CQC or the local authority safeguarding team when incidents occurred.
- Complaints were not satisfactorily resolved. One relative told us they had raised a concern but the complaint was not taken seriously by the provider, the issue was not addressed, and they now felt they could not speak out.
- There was no evidence of learning, reflective practice or service improvement. The provider and the manager failed to be aware of, or understand, up to date guidance and best practice in a number of areas, including infection control, COVID-19 government guidance and medicine management.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The management structure, and staff roles and responsibilities, were unclear. The new manager had not had a formal handover from the provider, who was the previous manager. The previous manager had applied to de-register before having another manager registered at the service. It is a condition of the provider's registration that there be a registered manager in place.

● The provider deployed surveillance throughout the corridors and communal areas of the home. The provider failed to comply with legal requirements around the use of CCTV in a care home setting.

● Quality assurance measures were ineffective. Very few audits were in place at the time of our inspection. There was no robust or effective system in place to assess and monitor the quality of the service.

This failure to set out clear roles, monitor the quality of the service, and comply with legal requirements was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service did not always comply with regulatory requirements. Services that provide health and social care are required to inform CQC of important events which happen in the service by submitting a 'notification'. During inspection we found the service had not informed us of four significant events.

The failure to notify CQC of four important incidents is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We are dealing with this matter outside of the inspection process.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The service did not always engage appropriately with people, relatives, staff and professionals.

● Staff meetings took place and all staff had recently had an appraisal with the new manager. However, some staff told us they could not raise issues with the provider, and they could not speak openly in the meetings. Staff comments included, "When I was raising concerns with management I wasn't getting anywhere", "If you question the provider about anything you are shot down in flames" and "If I had an issue I would not go to [the provider]. I wouldn't go to the manager either."

● Referrals to professionals were not made in a timely manner, or at all. Staff told us they were not allowed to seek medical attention for people without the provider's permission, which was not always given. One staff member told us, "One person had a number of falls in succession – we all raised concerns that [person] should be seen by the doctor, but the doctor was never contacted."

● Following a serious choking incident, the provider failed to take appropriate action and refer the person to the Speech and Language Therapy team for an assessment of their swallowing needs. This referral was subsequently made upon our request.

● We received mixed feedback from relatives about whether they were kept up to date. Some relatives told us communication was poor. Comments included, "I never know what is happening with [person]" and "The communication with us has been lax and re-active. It was generally up to me to ask the questions and up to me to find things out. I would say sometimes there is mis-communication." However, other relatives told us, "They keep me up to date and informed. They ring me and I will give them a ring as well."

This failure to appropriately engage with people and professionals was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to our inspection, the deputy manager had contacted the local authority medicines optimisation

team for support and requested a visit to discuss medicine management.

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 9(1), (2), and (3)(a) - (i) The registered provider failed to ensure that people using the service received person-centred care. The registered provider failed to ensure that people's wishes, choices and preferences were met.

The enforcement action we took:

Notice of Proposal to cancel 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 12(1), (2)(a)-(e), (g)-(h), (3) The registered provider failed to adequately assess, manage, monitor and mitigate risk to people's safety and wellbeing. The registered provider failed to ensure that premises and equipment were safe and used in a safe way. The registered provider failed to ensure that medicines were managed safely. The registered provider failed to have systems in place to support good infection control.

The enforcement action we took:

Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and

	improper treatment 13(1), (2), (3), and (4)(a) - (d) The registered provider failed to ensure that service users were protected from abuse and improper treatment.

The enforcement action we took:

Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17(1) and (2)(a) - (f) The registered provider failed to have systems and processes in place to support good governance of the service.

The enforcement action we took:

Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed 19(1), (2) and (3) The provider failed to have appropriate and robust recruitment procedures in place to ensure staff were fit and proper persons for the role.

The enforcement action we took:

Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 18(1) and (2)(a) The registered provider failed to ensure that service users were supported by a suitable number of appropriately trained and skilled staff.

The enforcement action we took:

Notice of Proposal to cancel the provider's registration.