Embrace (South West) Limited

The Laurels Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 29 January 2016 and was unannounced. When the service was last inspected in September 2013 there were no breaches of the legal requirements identified.

The Laurels Nursing Home is registered to provide accommodation and nursing care for up to 36 people. At the time of our inspection there were 25 people living at the service.

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

People's care plans were not sufficiently detailed to help staff provide personalised care based on current needs. Risks assessments relating to the health, safety and welfare of people were not effectively managed. Three of the four care plans we looked at contained risk assessments for areas such as falls, and moving and handling. The remaining care plan held insufficient details on how to keep the person safe as risk assessments had not been completed.

People's rights were not consistently being upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves.

Internal audit reports had failed to identify the issues identified during the inspection, such as the variable quality of the information held in the care plans and the failure to adhere to the principles of the Mental Capacity Act 2005.

Medicines were generally managed efficiently so that people received them safely. The nurse administering the medicines knew people well, knew who had been feeling unwell and who needed to be reviewed by the GP.

People were supported by sufficient numbers of staff to meet their needs. The provider made sure that all new staff were checked to make sure they were suitable to work at the service.

Staff were supported through an adequate training and supervision programme. New staff undertook an induction and mandatory training programme before starting to care for people on their own. Staff we spoke with demonstrated a good understanding of how to recognise and report suspected abuse. Staffing levels were maintained to a sufficient level to keep people safe.

People had their physical and health needs monitored. All care records that we viewed showed people had access to healthcare professionals according to their specific needs.

People spoke positively about the staff and told us they were caring. One person told us; "The staff are nice. They're all helpful. They discuss what I need" .Staff told us they aimed to provide personal, individual care to people.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

The overall feedback about the service and the registered manager had been positive. Staff spoke positively about the manager. People were encouraged to provide feedback on their experience of the service and monitor the quality of service provided. Identified issues were acted upon, such as the need for refurbishment.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks assessments relating to the health, safety and welfare of people were not effectively managed.

Medicines were generally managed efficiently so that people received them safely.

There were sufficient numbers of staff to meet people's needs safely.

Safe recruitment processes were in place that safeguarded people living in the home. A range of checks had been carried out on staff to determine their suitability for the work.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not consistently being upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves.

Staff were supported through an adequate training and supervision programme.

People's nutrition and hydration needs were met.

Staff monitored people's healthcare needs and made referrals to other healthcare professionals where appropriate.

Is the service caring?

Good

The service was caring.

People spoke positively about the staff and told us they were caring.

People were treated with kindness and compassion by the staff.

People and relatives felt listened to and were assisted by staff to achieve their aims.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not sufficiently detailed to help staff provide personalised care based on current needs.

People maintained contact with their family and were therefore not isolated from those people closest to them.

People told us they would feel comfortable to make a complaint and all felt any concerns would be fully investigated.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audit reports had failed to identify the shortfalls found during the inspection, such as the variable quality of the information held in the care plans and the failure to adhere to the principles of the Mental Capacity Act 2005.

Staff and people spoke positively the manager and they felt well supported.

People were encouraged to provide feedback on their experience of the service.

The Laurels Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 January 2016 and was unannounced. The inspection was undertaken by two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other enquiries from and about the provider and other key information we hold about the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who used the service.

We spoke with nine people that used the service, two relatives and five members of staff. We also spoke with the deputy manager, the registered manager and the regional manager.

We reviewed the care plans and associated records of four people who used the service. We also reviewed the medicines administration records (MAR's) of the people who lived at the home. We also reviewed documents in relation to the quality and safety of the service, staff recruitment, training and supervision.

Requires Improvement

Is the service safe?

Our findings

Risks assessments relating to the health, safety and welfare of people were not effectively managed. Three of the four care plans we looked at contained risk assessments for areas such as falls, and moving and handling. The remaining care plan held insufficient details on how to keep the person safe as risk assessments had not been completed. We were told this was due to the person being new to the service. The risk assessments that had been completed were thorough and the associated plans provided staff with guidance on how to keep people safe. One person's plan within the mobility section provided staff with details on how to move them safely, including details of which type of moving equipment should be used and which coloured sling. Plans informed staff to ensure people with mobility needs had their call bell close to hand and when we checked this was the case. However, it was not clear how staff monitored whether people knew when and how to use their call bell. On one occasion, one person was calling out for assistance, despite their call bell being beside them. We had to ring the bell and locate a member of staff.

During the inspection we saw that people had bed rails in place. We looked at the care plans of six people who had bed rails; although four of these had completed risk assessments in place, two did not. This meant that the risks associated with the use of bedrails had not been fully assessed.

One person had been assessed as being at risk of self-harming on 10/11/2015. Despite this, the care plan contained a mental health assessment that stated "All normal" and there was no care plan in place to inform staff how to support the person. This potentially placed the person at risk of harm.

Medicines were generally managed efficiently so that people received them safely. The nurse administering the medicines knew people well, knew who had been feeling unwell and who needed to be reviewed by the GP. They didn't rush people, asked if they would like their medicines and took their time assisting them when needed. PRN (as required) protocols were in place. PRN medication is only used for a specific situation, such as pain relief. Medicine Administration Records (MAR) charts were signed and up to date indicating that people had received their medicines as prescribed.

Medicines were stored safely and disposed of safely when no longer required. Controlled medicines were also stored safely and stock checks were undertaken daily. The medicines fridge was kept locked and items within had been signed and dated when opened. Medication audits had been completed and actions were taken forward where issues had been identified.

One person using the service was receiving their medicines covertly. Covert medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink. The covert administration of medicines should only be used in exceptional circumstances when such a means of administration is judged necessary, in accordance with the Mental Capacity Act 2005. An assessment of the capacity of the person should be conducted. A best interests meeting involving interested parties should take place before medicines are administered covertly. A mental capacity assessment was not completed and a best interest's decision making meeting did not take place to demonstrate how the decision was reached. Staff had not sought the appropriate professional advice to ensure that the crushing

of the tablets would not affect their mode of action and effectiveness. They had failed to adhere to own policy in relation to covert medication.

The provider made sure that all new staff were checked to make sure they were suitable to work at the service. These checks included seeking references from previous employers and obtaining information from the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were barred from working with vulnerable adults.

People told us they felt safe at the home and with the staff who supported them. They told us they could talk to any of the staff. One person told us; "I feel safe. This is my home I wouldn't want to be anywhere else." Staff told us they had received training in how to recognise and report abuse. Staff we spoke with had a clear understanding of what may constitute abuse and how to report it. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe.

Staff understood the term 'whistleblowing'. This is a process for staff to raise concerns about potential malpractice in the workplace. The provider had a policy in place to support people who wished to raise concerns in this way.

People were supported by sufficient numbers of staff to meet their needs. Staffing levels were assessed by following the Rhys Hear Dependency tool. The tool determines the level of staffing required whilst taking into account the dependency needs of the people who lived at the service. Staffing rotas demonstrated that staffing levels were maintained to the correct level. Where unexpected absences occurred the manager told us that they could call on existing staff to provide cover. We observed that people received support when needed, such as meal times and when medication was required. Staff also told us that the staffing levels were generally manageable. Staff comments included; "There is usually enough staff, unless someone goes off sick at the last minute" and "Staffing levels have got better lately". We received mixed comments from people. One person told us; "At the moment there seems to be more staff around, but weekends always seem short". Another person told us; "I think we used to have more staff, but it's not too bad".

The provider had appropriate arrangements for reporting and reviewing incidents and accidents. Incidents and accident forms were completed when necessary and reviewed. This was completed by staff with the aim of reducing the risk of the incident or accident happening. The records showed a description of the incident, the location of the incident and the action taken. The recorded incidents and accidents were reviewed by the registered manager. They reviewed the incidents and accidents and identified any emerging themes and lessons learnt. This analysis enabled them to implement strategies to reduce the risk of the incident occurring again.

People were cared for in a safe, clean and hygienic environment. Staff had received infection control training and knew their responsibilities in relation to the prevention and control of infection. Personal protective equipment (PPE) such as gloves and aprons were readily available and we observed staff using it prior to assisting people with personal care.

We observed that the hallways, rooms, communal areas and shared facilities were clean. Each room had a scheduled daily clean and schedules were completed. The kitchen had been awarded a five star food hygiene rating by the local authority. Daily and monthly cleaning schedules were completed and food was stored at the correct temperature. The chef told us that the kitchen was also steam cleaned every six months by contractors. Regular infection control audits were conducted which identified action items that needed to be taken forward. The most recent audit identified that some staff needed to refresh their infection

control and food safety training. The audit also identified slings being stored in the bathroom due to a lack of storage space and this required addressing.

Requires Improvement

Is the service effective?

Our findings

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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

The current DoLS arrangements showed that the staff had been involving the necessary people such as relatives, representatives and health professionals and followed a procedure to ensure they had an appropriate agreement to restrict people's rights. The registered manager advised that applications had been processed and sent to the local authority.

Where a person lacked mental capacity to make an informed decision, or give consent, staff did not act in accordance with the requirements of the MCA and the associated code of practice. The service did not always assess people's mental capacity prior to reaching best interest decisions. For example, in one person's plan, it was documented "Has been diagnosed with Alzheimer's and lack of capacity to make any decisions". Within the same person's bed rails risk assessment staff had documented that the person had not been consulted about the use of bed rails because "Dementia, lack of decision". Another person's mental capacity assessment stated they had "no capacity" and that the decision to use bed rails had been "discussed with the family previously. During discussions with staff, they did not demonstrate a clear understanding about the MCA and how it related to consent to care. Staff were unable to speak confidently about how they assessed a person's mental capacity and about the process for making best interest decisions.

Where a person lacked the mental capacity to make specific decisions about their care and treatment, their best interests were not established and acted upon in accordance with the Mental Capacity Act 2005. This included the duty to consult with others such as health professionals, carers, families, and/or advocates where appropriate.

This was in breach Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were supported through an adequate training and supervision programme. Staff told us they had received regular supervisions recently. We reviewed staff records which demonstrated that recent staff

supervisions had been conducted. This meant that staff received effective support on an on-going basis and development needs could be acted upon.

New staff undertook an induction and mandatory training programme before starting to care for people on their own. Staff told us about the training they had received; this covered a variety of subjects such as moving and handling, infection control, fire safety and first aid awareness. New staff members also shadowed more experienced members of staff until they felt competent to provide care on their own. The remaining induction training period was over 24 weeks and included training specific to the new staff member's role and to the people they would be supporting. A training plan was in place which demonstrated that the necessary mandatory training had been completed by staff members. A new induction training programme has also been introduced in line with the Care Certificate guidelines. These are recognised training and care standards expected of care staff.

People's nutrition and hydration needs were met. People were assessed for their nutritional needs, and when people required specialist support this was sought appropriately. People using the service said "The food is absolutely beautiful. If I don't like what's on the menu, they will always make me something else" and "The food is good here and we get plenty". We did note that when people were served their lunch in their room their hot pudding was served at the same time as their main course. This meant that the pudding may not be warm by the time people had eaten their main meal. This also occurred during the breakfast service. People's porridge and cooked breakfast were served at the same time.

People had access to healthcare services when required such as the physiotherapist and occupational therapist. On the day of our inspection an optician service was there to assess people. People also had regular access to the GP service. To enhance their level of effectiveness the service also held quarterly meetings with the GP practice. Issues discussed included any incidents that required a review, staffing, safeguarding and quality. Any issues identified by the GP were taken forward by the service. For example the need to enhance the consistency of their monitoring of specific medical conditions that require regular blood tests.

Good

Is the service caring?

Our findings

People and relatives spoke positively about the staff and told us they were caring. People's comments included; "They look after us very well. The staff are wonderful. They're good to us, kind and caring"; "The staff are very kind"; and "I am so grateful I came here". One relative told us; "The staff are very good and caring. First impressions are very good." A card recently received by the service stated; "We just wanted to say thank you for your care and compassion you showed our Mum during her final journey which she met on her own terms."

We observed that people were treated with kindness and compassion by the staff. There was a friendly atmosphere and staff knew people by name and vice versa. There were lots of positive interactions observed during the day. Staff were complimenting people and it was very well received. One person appeared disorientated and a member of staff provided reassurance and asked; "Would you like to come with me? Where would you like to go?"

All of the staff said they felt the team worked well together. One member of staff said "All the staff are really supportive. We work well as a team." Staff were knowledgeable about people's needs and told us they aimed to provide personal, individual care to people. Staff told us how people preferred to be cared for and demonstrated they understood the people they cared for. Staff gave examples of how they gave people choice and encouraged independence such as enabling them to make choices of clothes and drinks. We overheard one member of staff asking someone where they would like to eat their lunch. They said "It's up to you. You can come along to the dining room or have your lunch here (in the lounge). Whichever you prefer".

People were asked if they needed personal care and their decisions were respected. One member of staff told us; "I use persuasion but respect people's decision if they do not want personal care." One person told us; "I'm quite independent and if I need anything I'll ask. One of the carer's helps with the shower and stays with you to make sure you've got everything you want."

One member of staff told us about their keyworker responsibilities. The staff member told us that acted as a support buddy to their allocated person by sorting out any problems they may have. They also got to know the person's relatives and acted as their first point of contact. They told us; "[person's name] can't communicate so I seek the family views. I know their favourite clothes. If someone is unhappy I speak to the family as we're quite close to them." Another member of staff told us; "Because it's small here we get close, we're very family orientated. The care here is very good".

People and relatives felt listened to and were assisted by staff to achieve their aims. Comments included; "The manager has been supportive and made phone calls on our behalf regarding continuing healthcare"; "I feel well supported by staff and my mobility has improved significantly." and; "I discuss [relative's name] care with them. They listen. They're caring and knowledgeable."

Requires Improvement

Is the service responsive?

Our findings

People's care plans were not sufficiently detailed to help staff provide personalised care based on current needs. Two staff members said they had never read the care plans.

One person had moved into the service on 27 January 2016 but did not have a care plan in place. No risk assessments, or moving and handling assessments had been completed. There were no detailed plans in place for how to care appropriately for this person's specific medical conditions. . They were 'confused and anxious' according to documentation that was in place, but a mental capacity assessment had not been completed and there was no detail on how staff should support them.
Some people's mental health was assessed by staff as part of the care planning process. However, the documentation associated with this also demonstrated a lack of understanding by staff. For example, in two people's plans under the heading 'appearance', staff had documented 'normal'.

Two people's plans contained information in relation to their continence. Both plans stated that they wore incontinence pads, and informed staff to 'Check pads'. It did not inform staff how often they should check, the type of pads required, or inform staff of the importance of keeping the skin clean and dry. There was also no detail in relation to how staff should preserve people's dignity.

In another person's plan, it was documented that they sometimes refused personal care and could get 'anxious and violent'. The written planned support informed staff 'If refuses, leave for a few minutes and go back as may agree later in the day.' There was no detail on how staff should offer support or reassurance, how to distract, or protect themselves and the person from harm.

Another person's plan informed staff "Needs encouragement to socialise more". There was no other detail in relation to their personal preferences, or how staff should encourage them. The overall lack of detail and the fact that some staff had not read the care plans meant that there was a risk that people might not receive care that was responsive to their needs.

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

A dedicated activities coordinator was employed by the service. There was a structured weekly activities programme. This included pottery, flower arranging, exercises, bingo and games. Many of the people we spoke with provided positive feedback about the activities programme and took part when they wanted to. However one person thought they were "boring."

People maintained contact with their family and were therefore not isolated from those people closest to them. Relatives were welcomed to the service and could visit people at times that were convenient to them. One person commented; "My family come to visit. They can visit anytime. My daughter visits every Sunday and we do puzzles together."

The provider had systems in place to receive and monitor any complaints that were made. No recent formal complaints had been received. People said they knew how to complain, but had never had cause to. They felt confident that they would be listened to and their complaint would be investigated by the manager. One person said "I would speak to the manager if I had a problem".

A number of recent compliments had been received by the service. Comments included; "Thank you for your kindness to Mum making her six month stay with you cheerful and comfortable."; "I'm glad he was in your care in his final days. You were all so kind." and; "Your care and dedication gave us peace of mind; in the knowledge that she was being well-looked after in her home at The Laurels."

Requires Improvement

Is the service well-led?

Our findings

The regional manager visited the home regularly and compiled a monthly visit report. The visits were used as an opportunity for the regional manager and manager to discuss issues related to the quality of the service and welfare of people that used the service. Clear action plans were evident and timescales given to areas in need of attention. Actions from previous monthly visits were reviewed to ensure appropriate actions had been forward within the required timescales. We did note that the reports had failed to identify the issues found during the inspection, such as the variable quality of the information held in the care plans and the failure to adhere to the principles of the Mental Capacity Act 2005. A new regional manager has recently been appointed. They were provided with feedback of our inspection findings on the day to take forward and action.

In the main there were appropriate governance systems in place to monitor health and safety and the welfare of people. These included audits on fire safety records, legionella, water temperatures, maintenance of safety equipment, gas safety, boilers, call systems, portable appliance testing (PAT) and window restrictors. Where actions were identified they were taken forward within set timelines. An example of this included where the service had tested a low positive result for legionella, as a result all showers were stopped due to a risk of spores and only baths were provided in the interim period. To minimise disruption showerheads were ordered and delivered the next day and then they were reinstated across the service.

Staff and people spoke positively the manager and they felt well supported. They said they felt able to speak up with any concerns and felt confident that their concerned would be listened to. One member of staff told us; "I would approach the manager. She's brilliant."

The manager communicated with staff about the service to involve them in decisions and improvements that could be made; we found recent staff meeting minute's demonstrated evidence of good management and leadership of staff within the service. Agenda items identified action items which needed to be taken forward such as the need to contact the service directly when people are off sick. Staff were informed of the need to follow this practice in order to ensure that their shift could be covered as soon as reasonably practicable. The minutes also provided a company update and encouraged staff to discuss issues they had.

The provider sought feedback from people using the service so that they could evaluate the service and drive improvement. People are able to make comments directly on the provider's website. Annual customer surveys are also conducted. Recent comments made on the provider's website included; "The staff treat me very well, treat me with dignity. The food, you get a good choice. The other clients are very friendly" and "I have no complaints at all. Staff are excellent, staff look after me well. Food is good. I will recommend to anyone. All staff treat my wishes with dignity and respect." The overall comments received from the 2015 questionnaire were positive regarding the care and support. Some concerns had been expressed regarding the décor. One person commented; "The Laurels despite being in need of decoration is always clean and the toilets and bathroom and wash areas are spotless. We would highly recommend The Laurels." The provider has taken the feedback on board and we noted that there was planned refurbishment scheduled for this year.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plans were not sufficiently detailed to help staff provide personalised care based on current needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not consistently being upheld in line with the Mental Capacity Act (MCA) 2005. Where a person lacked mental capacity to make an informed decision, or give consent, staff did not act in accordance with the requirements of the MCA and the associated code of practice.