SHC Rapkyns Group Limited

The Laurels

Inspection report

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18 November 2020

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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

The Laurels is a residential care service that is registered to provide accommodation, nursing and personal care for people with learning disabilities or autistic spectrum disorder, physical disabilities, and younger adults.
The service was registered for the support of up to 41 people. At the time of the inspection nine people were using the service.
The service consisted of four separate Lodges within one building. At the time of the inspection, all nine people were living in one lodge. Two people from these eight were staying with relatives, so there were seven people staying in the lodge when we visited.
The Laurels is owned and operated by the provider Sussex Healthcare. Services operated by Sussex Healthcare have been subject to a period of increased monitoring and support by local authority commissioners. Due to concerns raised about the provider, Sussex Healthcare is currently subject to a police investigation. The investigation is on-going, and no conclusions have yet been reached.

People's experience of using this service and what we found.

There was unsafe assessment, monitoring and management of risk for people with support needs regarding constipation, behaviours that may challenge, choking, breathing, skin integrity, mobility and posture.
Risks around people's deteriorating health and well-being were inconsistently managed and monitored by staff.
Medicines were not always managed safely. People had not always received their medicines as intended when they needed them.
People were not always safeguarded from abuse.
Lessons were not always learnt, and actions not taken to investigate safety incidents, and prevent them re-occurring.
Staff practice, and reporting systems to safeguard people from abuse, were not always effective to ensure people were safe from harm.
Staff did not always have the required competencies or knowledge to safely meet people's individual needs.

Service management, and the provider's wider quality assurance and governance systems, had not always ensured actions were taken to address any issues and risks in a timely manner. People's care records were not always up to date or accurate.
The provider had failed to act upon known areas of concern, non-compliance, and risk to improve the quality of care for people at The Laurels. This had exposed people to on-going poor care and risk of avoidable harm.
Staff told us they had not always worn the correct personal preventative equipment (PPE) when supporting people. The provider acted immediately to address this with staff and offer additional training and guidance. The provider had ensured there were adequate stocks and supplies of PPE available.
The provider had acted to manage other infection risks during the Covid-19 pandemic. Additional infection

prevention and control measures in line with Department of Health and Social care guidelines had been put in place to ensure people's safety.
Staff had alerted appropriate external agencies when they had displayed signs and symptoms of Covid-19. This had helped prevent infection and maintain people's health and well-being.
Relatives told us the service was always clean and well maintained whenever they had visited, or from what they had seen on video calls.
We observed there was a high ratio of staff supporting people during the inspection. Staff and people said there were currently enough staff. Relatives told us they thought staffing levels had improved and more staff had been recruited recently.
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.
The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:

The model of care and setting did not maximise people's choice, control and independence.
The service was in private grounds in the countryside. Opportunities for people to access the local community were limited. Staff wore uniforms and name badges to say they were care staff when coming and going with people.
The service is bigger than most domestic style properties. There were identifying signs on the road before the service's private drive, the service grounds and on the exterior of the service to indicate it was a care home.

Right care:

Care was not always person-centred or promoted people's dignity, privacy and human rights.

People were not supported safely.
People were not always listened to.
Staff did not always respond in a compassionate or appropriate way when people experienced pain or distress.

Right culture:

The management team had begun to plan how to work to ensure they could provide good quality personalised, respectful support for people living at the service.
People had recently been allocated keyworkers, to help them get the support they needed and wanted.
Staff said they were being encouraged to understand how to support people in a person-centred way.
We observed staff supporting some people in a positive manner during our inspection visits
However, significant work was still needed to change the existing culture, ethos, attitude and practice of staff at The Laurels in order to achieve this vision.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was Inadequate (published 9 July 2020). The service has been rated requires improvement or inadequate for the last eight consecutive inspections.
At the last inspection we found multiple breaches of regulations. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

This was a planned inspection based on the previous rating.
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 coronavirus and other infection outbreaks effectively.
We carried out a comprehensive inspection on 20 and 21 August 2019 and an announced targeted inspection on 19 May 2020. Breaches of legal requirements were found at both inspections.
We undertook this focused inspection to confirm the provider now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has not changed. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Laurels 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 four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulations 12, 13, 17, 18 in relation to: safe care and treatment, safeguarding people from abuse, good governance and staffing.
We have also identified a breach of Care Quality Commission (Registration) Regulations 2009 regulations 14 and 18 in relation to failing to notify CQC of incidents regarding staffing, abuse or allegations of abuse in relation to service users and of the absence of a registered manager.

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. The Laurels is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

Follow up

We will continue to monitor information we receive about the service until we return to visit. If we receive any concerning information we may inspect sooner.
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 act 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.

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.
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

This inspection took place on 17 and 18 November 2020. The inspection team consisted of two adult social care inspectors and a medicine inspector.
On 17 November 2020 all three inspectors carried out an inspection visit to the service. On 18 November 2020 two adult social care inspectors visited the service. Following the site visits all three members of the inspection team reviewed care records and spoke with staff and relatives remotely.

Service and service type

The Laurels 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.

At the time of the inspection, the service had a manager registered with the Care Quality Commission. The registered manager had been absent from managing the service for over 28 consecutive days. The service had two other managers from within their organisation running the service while the registered manager was away.
On 7 December 2020 the manager de-registered with the CQC. This means the provider now has sole legal responsibility for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was announced on the day of our first site visit on 17 November 2020. When we announced the inspection, we worked with the provider to agree the safest way to inspect during the Covid-19 pandemic to minimise the risks to people who live at the service, staff and our inspection team.

What we did before the inspection

Before the inspection, we reviewed information we held about the service. We considered the information which had been shared with us since the last inspection by the provider as well as the local authority, other agencies and health and social care professionals.

During the inspection

We spoke with both managers overseeing the service, the clinical lead, registered nurses (RGN) and various support staff. We spoke with the chief operations officer and the director of quality. The director of quality is also the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.
We reviewed people's care and medicine records. We spent time talking to and observing people being supported, including during lunch. We visited some people's bedrooms.

After the inspection

We reviewed copies of people's care and medicine records, training records, rotas, incident reports and quality assurance records. We spoke with the managers and clinical lead, an RGN, two support workers and four relatives of people using the service via telephone.

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

Assessing risk, safety monitoring and management

● Risks to people with respiration (breathing) support needs were not always assessed, monitored or managed safely. One person had been assessed as needing support from staff to have twice daily postural rest and drainage sessions. This was to reduce the risks of them getting chest infections caused by breathing fluids into their lungs. The person had experienced repeat chest infections recently and been seriously unwell.
● However, staff were not supporting them to have their postural drainage every day. Staff were not aware of the person's assessed need for this or could not explain why they had not been doing this. The person had been placed at a high level of avoidable risk of getting another chest infection and becoming seriously unwell again.
● A person required support to use a machine every night to help them breathe due to their respiration difficulties. If the person did not have enough oxygen this could be harmful to their well-being. Staff had not always recorded they had supported the person to use the machine that helped them breathe at night as required. It could not be confirmed the person had got as much oxygen as they needed on these occasions and this had not been checked by nurses or managers.
● There had been several incidents, including a ten-day period, when staff had not given the person their oxygen treatment as their equipment was broken. During these times, staff had not always followed the directions in the person's risk assessment about what to do to make sure the person was safe in this situation. Although there had been a continued risk to the person's well-being, there had not been any action to prevent this by staff.
● Risks of aspiration (breathing in liquids, food or saliva) and choking for people were not always assessed, monitored or managed safely. One person had problems swallowing and could choke on food or drink. The person needed to be supported to have very small portions of smooth food and to eat slowly. We observed staff feeding the person heaped spoons of food at a faster pace than their guidelines stated.
● Although there was information about how to support this person safely, the staff member was unaware of this. Other staff present observed this unsafe care, but did not intervene to prevent it from happening. This had placed the person at high risk of choking or inhaling food into their lungs, which could cause them serious harm.
● Some people were at such high risk of aspiration or choking they were 'nil by mouth' and could not take some, or all, food, fluids and medicines orally. There had been an incident where staff had not been aware of guidelines about how to support a person who was assessed as 'nil by mouth' and given them food that was unsafe. This had caused the person to vomit and become unwell.
● Some people living at the service received food, fluids and medicines via a tube to their stomach to help prevent them aspirating due to swallowing difficulties. Staff had not always recorded they had paused

people's food or elevated them to a safe angle when supporting them. This had not been checked or reviewed to make sure they were safe from any aspiration risks.

● Risks to people with epilepsy were not always being monitored, assessed or managed safely, exposing them to high risk of harm. One person had not been given their required medicine or oxygen when they had an epileptic seizure. This could have caused long term serious harm or been potentially life threatening.

● For three people living with epilepsy, we found inconsistent and conflicting information in their epilepsy care plans, risk assessments, and protocols for administering medicines while they were experiencing a seizure. Staff were not aware of this and there was a significant risk that people could receive incorrect or unsafe support.

● Risks relating to people's constipation needs were not assessed, monitored or managed safely. People living at this service with profound and multiple learning disabilities were more likely to become constipated. All people living at this service were at increased risk of harmful medical complications if they became constipated.

● People's continence care plans and constipation protocol care plans contained inconsistent advice about the medicines and support they needed. This increased the risk people may not get help to prevent constipation or to get help if they were constipated.

● Staff had not always acted to support people if they were constipated. One person had not received laxatives when they required them, increasing the risks to their safety and well-being. Nurses and managers were not aware of these issues and had not checked to see people were being supported safely.

● Risks relating to people's physical and non-physical behaviours that may challenge were not always assessed, monitored or managed safely. Several people could display behaviours causing emotional distress or physical harm to themselves, or other people and staff at the service.

● Since the last inspection there had been repeated instances of several people displaying physically challenging behaviours towards others. This had resulted in minor injuries and emotional upset for people and staff.

● There was not enough guidance or information available in people's care plans and risk assessments about what their behaviours may mean or how to safely support them. Staff were not always supporting people to learn new skills to help prevent and reduce their behaviours that may challenge. This increased the risk people might get hurt and continue to display potentially unsafe behaviours towards themselves and others.

● People's behaviour monitoring forms often did not have enough detail or capture relevant information. It could not be confirmed people had always been supported safely, and managers had not checked this.

● Risks associated with ensuring people's health and well-being was maintained were not always assessed and monitored safely.

● Staff had not taken people's vital health observations, such as blood pressure, oxygen saturation and heart rate, when required according to their care plans and risk assessments. For example, when they had become unwell or following an epileptic seizure. This increased the chances that staff may not recognise and act if people's health declined suddenly and support them to access healthcare support and services quickly.

● Risks relating to people's skin integrity were not always assessed, monitored or managed safely. Many people at the service were at risk of developing pressure sores or having skin breakdowns due to their physical disabilities and health conditions.

● One person required support to do daily exercises to help maintain their skin integrity but had not received this support for several months. This exposed them to avoidable risk of skin damage.

● There were inconsistencies in advice and guidance for staff about how often to re-position a person at night to avoid the risk of pressure sores. Staff did not know what support the person needed. Some staff were re-positioning the person regularly at night, but other staff were not. Staff and managers had not checked this to make sure this risk was being manged safely.

Using medicines safely

● Medicines were not safely managed.
● Medicines administration protocols were not always being followed, placing people's well-being at risk.
● One person had not been offered laxatives when they had become constipated and needed them and had been given laxatives when they did not need them. Another person had not been given their regular epilepsy medicine as needed.
● Some people were being given medicines daily when they had been prescribed as and when needed (PRN). Staff had not always recorded the reason they had given people PRN medicines.
● People's PRN protocols and associated care plans did not give staff clear directions about how and when to give prescribed medicines, including medicines used to treat epilepsy and constipation. PRN protocols were missing or had not been reviewed regularly for some medicines. This increased the risk people may not receive their medicines safely, or as intended.
● Medicine audits were not effective. Audits had not always been carried out as often as the provider's policy said. Audits did not always find when things had gone wrong or needed attention. When audits had found issues, action was not always taken by staff and the issues had remained for a long time.
● Staff had not identified minimum and maximum temperature ranges for medicines that needed to be kept in the fridge. This increased the risk staff may not know if medicines were being stored safely.

Learning lessons when things go wrong

● Systems in place for staff and management to report, review and investigate safety incidents, and act to prevent them re-occurring were not always effective. This increased the risk that incidents would not be investigated and acted on to prevent them from happening again.
● During this inspection we identified risks, issues and concerns relating to safety incidents that had either not been reported or had not been adequately acted on regarding people's constipation, respiration, choking, epilepsy, behaviours that may challenge, medicines, skin integrity, healthcare monitoring, mobility and postural support needs.
●Following our previous inspection in July 2020 we acted to impose conditions on the provider's registration due to our serious concerns regarding behaviours that may challenge, medicines, the management of epilepsy/seizure treatment, constipation, choking and aspiration, nutrition and hydration and service users' deteriorating health.
● However, despite this action we found the same issues and concerns in these areas of people's support at this inspection. The chief operating officer and director of quality acknowledged the service had not been able to learn and make improvements quickly enough in these key areas of people's support.
● The themes of risks and concerns found at this inspection relating to people's behaviours that may challenge, choking, respiration, constipation, skin integrity, epilepsy, medicines, monitoring healthcare and postural and mobility support needs have been highlighted in inspection reports about many of the provider's other services. This information had not led to the provider acting to reduce similar risks to people at The Laurels..

The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users, thoroughly review, investigate, monitor and act to make improvements in relation to incidents that affect the health safety and welfare of service users or manage medicines safely. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Immediately following this inspection, the provider told us they planned to review their learning disability

services, including The Laurels, in response to repeat concerns they could not safely or effectively meet the needs of the people living there.
● The provider offered assurances they would ensure that work was invested in addressing safety concerns and managing risks to people's welfare in the period of the review and throughout any changes.
● The provider is required to tell us each month about how they are reviewing and making changes to be able to deliver safe and effective support for people. This includes how they are providing care safely for known risks associated with people's 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. We are monitoring this information and will liaise with the provider in response to any concerns.
● We received a mixed response from relatives we spoke with about risk management. Some relatives told us staff had helped to manage potential hazards to their family members health and well-being very well. Other relatives said their family members needs had not always been safely met.

Systems and processes to safeguard people from the risk of abuse

● Staff did not always recognise and report potential safeguarding abuse incidents. Immediate review and investigation to protect people from any abuse or improper treatment had not taken place.
● One occasion a person told staff about a possible physical and psychological abuse situation involving another staff member. The person was very distressed by the experience when they told staff about this. Staff recorded what they had been told and the person's emotional upset as the person presenting a behaviour that may challenge.
● Staff told the person they would tell the manager about what had happened, but they did not do this. No other action was taken to report, investigate and protect this person and other people. The staff member who the person had raised concerns about had continued to work with the person and other people.
● Systems and process to ensure people were kept safe from other forms of abuse and improper treatment were not operating effectively. Staff had neglected people's medicines, respiration, constipation and choking support needs. Staff had not provided proper treatment for people's skin integrity, physiotherapy and behaviours that may challenge support needs. Staff had not identified or acted in response to these abuse concerns. Instances of neglect and improper treatment had been repeated over long periods.
● Since the last inspection in May 2020 partnership agencies visiting the service had raised safeguarding concerns regarding staff neglecting people's continence, nutrition and aspiration support needs. The provider was not always aware of or had reported these concerns themselves.

The provider had failed to ensure systems and processes protected people from abuse and improper treatment. This is a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We made the provider aware of the potential abuse situation when we read the behaviour monitoring chart during the inspection. We asked the provider to act straight away. The provider began an immediate investigation and took steps with the staff involved to keep people safe while this was taking place.
● The provider also acted to offer additional refresher safeguarding training and guidance to all staff.
● Some relatives told us they thought their family member would not be afraid to speak up if they did not feel safe. Some relatives told us they had regular contact with their family member, both through visiting and via video calls. They said they had never had any concerns about their family member being exposed to risk of abuse since they moved to the service.

Staffing and recruitment

● There were insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. People living at the service required regular weekly physiotherapy and hydrotherapy support from staff at the service to help improve or maintain their posture and other health needs. Due to Covid-19 risks, people were unable to access the hydrotherapy pool since March this year. The provider had agreed to provide land-based physiotherapy sessions to replace people's hydrotherapy.
● However, since March this year there had been shortages of physiotherapy staff and not enough staff had been deployed to meet people's needs. People had not received their required number of their physiotherapy or hydrotherapy replacement sessions. Actions to assess and reduce the risk of any missed physiotherapy sessions, including replacement sessions for hydrotherapy, had not been taken. This placed people's safety and well-being at increased risk.
● Staff had not received adequate training or support to be able to deliver safe or effective support for people with behaviour's that may challenge. This placed people and staff's safety and well-being at increased risk. Staff did not demonstrate they were skilled enough to meet people's behaviour that may challenge support needs safely or effectively. Less than half of the permanent staff had received 'behaviour support documentation' training. Staff were not competent and could not complete behaviour support documents to a good standard.
● We have provided more information about how staffing issues had increased risks to people's safety and well-being in the 'Assessing, monitoring and managing risks' section of this report.

The failure deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We are receiving information about on-going work between the local NHS Trust and the provider to look for solutions to assess people's physiotherapy needs and associated risks and provide enough staff to meet people's needs. The provider is in the process of recruiting qualified staff to support staff across their organisation to deliver safe and effective support for people with behaviours that may challenge.
● There had been a recent safeguarding raised regarding low staffing levels at the service and people's needs being neglected because of this. Managers and staff told us staff numbers had been cut recently but following internal complaints and the safeguarding being raised, the provider had agreed for more staff to be allocated to the service.
● We observed there was a high ratio of staff supporting people during the inspection. Staff and people said there were currently enough staff. Relatives told us they thought staffing levels had improved and more staff had been recruited recently.

Preventing and controlling infection

● We were not always assured that the provider was preventing visitors from catching and spreading infections.
● We were not assured the provider had always been using PPE effectively and safely.
● Staff we spoke with told us they had been using incorrect PPE when supporting people with Aerosol generating procedures (AGP).
● We spoke to the provider about this during the inspection. The provider was aware of the correct PPE to use and re-visited this guidance with staff straight away.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● Relatives told us the service was always clean and maintained whenever they had visited or from what they had seen on video calls.One relative told us staff had adapted the service premises according to their family member's individual needs regarding Covid-19 risks, to ensure they had been kept as safe as possible from infection.

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 comprehensive inspection this key question was rated as inadequate. At this inspection this key question has now 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, continuous learning and improving care, 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

● At the last inspection in May 2020, we had found that the provider was in breach of regulations 12, 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, safeguarding people from abuse and good governance.
● Following the inspection in May 2020, we had specific concerns about unsafe epilepsy, constipation, behaviours that may challenge, nutrition and hydration, choking and aspiration support, medicines not being managed safely, staff failing to monitor and act in response to people's deteriorating health and people being at risk of abuse.
● We had imposed conditions on the provider's registration in May 2020 telling the provider that they must employ the services of behaviour support specialists and assess, monitor and act to help ensure people with all the above needs were supported safely and effectively. We asked them to send us monthly reports to tell us how they were doing this.
● We had previously imposed conditions in June 2018 in response to serious concerns about people's safety and well-being. We told the provider they could not admit any more people to the service without consultation with us to help make sure this was a safe enough thing to do. During this period the number of people living at the service had declined from 27 to the current total of nine people.
● In June 2018 in response to concerns about unsafe medicines management, we told the provider they must employ specialist pharmacist and medical advice to help them improve.
● Despite significantly decreased numbers of people to support and the imposition of multiple conditions since June 2018 the provider had not been able to improve or prevent repeat themes of concern re-occurring in relation to people's safety or the quality of care at The Laurels.
● At this inspection in November 2020 we found staff continued to fail to monitor and act in response to people's deteriorating health. People remained at risk of abuse. Medicines were not managed safely. Risks to people who required support for their epilepsy, constipation, behaviours that may challenge, nutrition and hydration, choking and aspiration support had remained high and their needs continued not to be met safely or effectively.
● We also found the quality and safety of people's support had deteriorated further from our previous inspection in May 2020. People's health and welfare was at risk due to the provider's failings to provide safe support with skin integrity and mobility and postural support needs. There were not enough skilled or

knowledgeable staff to meet people's needs safely or effectively.
● At this inspection in November 2020 we found breaches of regulation 18 in relation to staffing and a breach of CQC Registration Regulations 14 and 18 regarding failing to notify the CQC of incidents, in addition to repeat breaches of regulations 12, 13, and 17.
● The risks and concerns found at this focused inspection follow themes which have been repeatedly highlighted in inspection reports about many of the provider's other services.
● In December 2018 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 several 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 and how they are acting to resolve any risks to people's safety and wellbeing.
● These provider level conditions and repeated reporting of information about themes of unsafe care for people being supported provider's organisation had not led to similar risks to people at The Laurels being reduced.
● Systems and processes to assess, monitor and improve the quality and safety of the service were not operating effectively. The registered manager had been absent from the service since the beginning of September 2020. There were two other managers and a deputy manager/clinical lead overseeing the service in the registered manager's absence. The managers and clinical lead had all been carrying out a regular variety of internal audits to check the quality and safety of the support people were receiving.
● The management and staff at the service had received consistent additional support from managers and support teams within the organisation. There had been support from external medicine and behaviour specialists to check and carry out other audits to help ensure the delivery of good quality and safe care for people.
● However, these quality assurance systems and processes had not always identified or prevented significant safety issues occurring or continuing at the service. Where issues had been identified, there had not always been effective action to maintain or improve the quality and safety of the support being delivered. Staff at all levels had not demonstrated they understood or fulfilled their responsibilities. Staff had not always met people's support needs or reported and acted in response to quality and safety issues.
● Both the nominated individual and the chief operating officer told us the service had not been able to deliver an adequate standard and quality of support. However, staff accountability had not been managed effectively to prevent this happening. Staff continued to not always have the right skills, knowledge or experience to manage risks and deliver safe care for people.
● People did not always have an accurate and contemporaneous record of their care in place. Despite repeated re-writes and reviews by mangers, people's care plans, risk assessments and monitoring forms regarding constipation, behaviours that may challenge and epilepsy were not always accurate, complete or up to date.

Working in partnership with others

● We found specific examples during this inspection regarding the provider failing to work effectively with partnership agencies to ensure people's eating and drinking, physiotherapy and respiration needs were met, and associated risks managed safely. This has been reported in more detail in the Safe section of our report.
● The local authority and local NHS partnership trust provided feedback that staff continued to not always act when they made recommendations, despite a lot of guidance and resource being invested in supporting staff to improve the standard of care being delivered. One of the service managers told us that there had been issues with staff engaging and working with outside agencies in a positive manner.
● There had been repeated occasions where external professionals had raised safeguarding concerns where

they felt this had placed people's safety at risk. Partnership agencies shared concerns regarding the provider's communication and information sharing not being open and transparent, including when things had gone wrong.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider had recently invested in an independent learning disability specialist organisation to review their service delivery across their registered services. This review had highlighted significant and multiple shortfalls in the provider's model and approach to delivering care to people.
● The review concluded significant changes and improvements were needed to be able to deliver, person-centred, open, inclusive and empowering support which achieved good outcomes for people that fully considered their equality characteristics.
● Both the chief operating officer and the nominated individual acknowledged the validity of the reviews' conclusion, how this was reflected in the findings at this inspection of The Laurels and the corresponding levels of concern this presented.

The provider had failed to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved. The provider had not ensured there was a positive and open culture that achieved good outcomes for people.

This was a continued breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The provider had not always informed relevant partnership agencies such as the local authority safeguarding team, local NHS trust partnership, or CQC about notable safety incidents, risks or events that stop the service, as per their statutory and contractual responsibilities.
● Notifications had not been sent to CQC as required regarding people not being provided with their assessed physiotherapy or hydrotherapy needs due to staffing issues. CQC and the local authority had not been notified in a timely manner, or at all, when staff neglected to meet people's respiration, epilepsy and constipation needs, or when people had been exposed to risk of harm and abuse. The provider had not notified the CQC as required when their registered manager had been absent from managing a regulated activity for 28 consecutive days.

The failure to ensure that all statutory notifications of a registered manager absence and of incidents related to services of a regulated activity being provided at the location were submitted as required is a breach of Regulations 14 and 18 of the Care Quality Commission (Registration) Regulations 2009.

● Following this inspection, the provider informed people living at the service, staff, relatives and partnership agencies of their plans to review their learning disability services, including The Laurels, in response to concerns they could not safely or effectively meet the needs of the people living there.
● The managers told us they had been committed to ensuring improvements were made although there had been a lot of challenges to being able to realise this quickly enough.
● We received mostly positive feedback from staff about the current managers at the service, who they said were approachable and had a visible presence.
● Relatives we spoke with said they had no concerns about the current service managers' management of

the service. Relatives told us they thought there was a positive and friendly culture amongst the staff at the service.

● All relatives felt previous managers at the service and the senior leadership team within the organisation had not always been open or communicated well. This included ensuring they had been kept up to date about planned changes and improvements at the service.

● We received mixed feedback from people about staff and the culture at the service. One person said they did not always feel safe or respected. Other people told us they really liked the staff and they helped them to do things they wanted.

● There had been regular meetings with people and relatives to gain their views and include them in the running of the service. Relatives gave us mixed feedback about these processes. One relative told us how following these meetings some of their suggestions about outings for people had been acted on. Another relative told us recently they felt like they were not always listened to and when they were made to feel like "a nuisance".

● Managers had told us there had been a recently developed company set of values that included integrity, respect, accountability, and compassion. They had begun to work with staff to help them to understand what good care should look like and how to apply these values in their roles via discussions and supervisions.

● Some staff told us they wanted to support people in a person centred and compassionate way. We saw some staff supporting people in a positive and empowering way, such as communicating with them in accessible ways to help understand their choices.

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 14 Registration Regulations 2009 Notifications – notices of absence
Treatment of disease, disorder or injury	Failure to submit a statutory notifications regarding a registered manager absence as required

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. The Laurels is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	Failure to ensure that all statutory notifications of incidents related to services of a regulated activity being provided at the location were submitted as required

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. The Laurels is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

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, thoroughly review, investigate, monitor and act to make improvements in relation to incidents that affect the health safety and welfare of service users or manage medicines safely.

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. The Laurels is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure systems and processes protected people from abuse and improper treatment.

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. The Laurels is now de-registered and the provider is no longer able to provide regulated activities at or from this location.

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 ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved. The service had not ensured there was a positive and open culture that achieved good outcomes for people.

The enforcement action we took:

We took enforcement action to issue a Notice of Decision to vary a condition of the provider's registration and remove this location. The Laurels is now de-registered and the provider is no longer able to provide regulated activities at or from this location.