Superior Care Homes Ltd

The Laurels Residential Home

Inspection report

The Laurels, Bull Lane
South Kirkby
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West Yorkshire
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Tel: 01977640721

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22 February 2016
23 February 2016
25 February 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 22, 23 and 25 February 2016 and was unannounced. The service was last inspected on 9 November 2013, and was found to be compliant in all areas inspected.
This inspection was in response to concerns which had been raised. These concerns related in particular to the manager and their attitude towards people living and working at the Laurels. The Concerns also related to gifts being taken from people living in the Laurels by the manager.

The Laurels Residential Home provides accommodation and personal care for up to 28 older people. At the time of inspection respite care was also provided. The home was spaced over two floors with bedrooms on each floor.

The registered manager and deputy manager were on annual leave at time of our 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. Because of the multiple and serious nature of the findings of the inspection we spoke with the owner of the home, and they brought in staff from another organisation to support the leadership in the home. This would be in the short term while initial investigations could be completed into the suitability of the present management to fulfil their roles
We found the standards of care in the service had deteriorated significantly since our last inspection. There were multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff did not recognise safeguarding incidents that were occurring. There had been no safeguarding referrals made to protect vulnerable people living in the service until incidents were highlighted by CQC during the inspection.

There were very few risk assessments in place for people in the service and those that were in place were not adequate to identify and reduce identified risks to keep people safe. We found several people using equipment which was not identified in their risk assessments. And risk assessments for equipment which staff did not know should be use.

We found that DBS checks were used from other organisations for some staff. DBS checks were carried out when people commenced working at The Laurels but were not checked again which meant the provider was unable to confirm that ongoing suitability of staff is routinely monitored and verified to ensure they remain suitable to work with vulnerable people.

We found people in the service were not treated with dignity and respect. Staff alleged that some of the people living in the service had their rooms used as a treatment room for visiting professionals without their consent.

Staff alleged that gifts were routinely taken from people and locked away until decisions were reached about when people could access these. Staff did not recognise how people's dignity and fundamental human rights could be promoted.

We found people's care needs had not been adequately or accurately assessed and there was no care plan in place for any of the people on day care or respite care. People's care plans were out of date and the information did not reflect their current needs or describe the care which required by them or was being given to them.

The people living in the service were not asked for their consent for care to be carried out. The staff failed to recognise restrictive practices which were in place. Mental capacity assessments were not carried out for the people living in the service to measure whether they were able to make their own decisions and which decisions they were able to make. Where people's liberty was being restricted there were no Deprivation of Liberty Safeguards in place.

We saw that food records were inaccurate and were not filled in at mealtimes, which meant staff could not accurately monitor people's food and fluid intake. We found evidence of weight loss in some of the people living in the service, and people were not being weighed regularly to monitor their weight.

There were no processes in place to monitor the performance of the service or to maintain accurate records of the care which was being delivered. We found that there was no effective leadership within The Laurels. Staff alleged that they were spoken to in an unprofessional manner by the senior staff at the home. Staff were not empowered to make decisions and this impacted on the health and safety of the people living in the Laurels.

We found that staff supervision was not adequate and did not offer any opportunity for staff development Staff were not well trained and were not competent in all areas of their roles. There was no evidence of recent training the last documented training was October 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this time frame. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement or there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration .For adult social care services the maximum time for being in special measures will usually be no more than12 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

Management and staff did not have a good understanding of their responsibilities in relation to safeguarding

Accident and incidents were not recoded consistently

Risk assessments were not accurate and reflective of the person.

The premises were not clean

There was a lack of hot water

Administration, storage and disposal of medicines was not safe

Safe recruitment was not in place.

Is the service effective?

Inadequate

The service was not effective

Management and staff did not understand the mental capacity act (MCA) or Deprivation of Liberty Safeguards (DoLs)

The only choice we saw offered were a choice of food at meal times

Staff supervision was inadequate

Is the service caring?

Inadequate

The service was not caring.

Peoples privacy and dignity were not respected

Peoples right to a home life was not upheld

Staff were task orientated.

No access to advocacy.

Is the service responsive?

Inadequate

The service was not responsive.

There was a lack of activity for people cared for in bed.

We found that care was not person centred and built upon peoples preferences

Peoples life histories were not completed as part of care planning.

No complaint file available for review.

Is the service well-led?

Inadequate

The Service was not well led

Staff alleged that the senior management at the home exhibited unprofessional behaviours

Quality assurance processes were poor and documentation relating to care was inadequate

The senior management at the home had failed to communicate incidents of concern to the CQC as legally directed to do so

The Laurels Residential Home

Detailed findings

Background to this inspection

This inspection took place on 22, 23 and 25 February 2016 and was unannounced. The inspection team consisted of three adult social care inspectors and a specialist advisor in mental health conditions, one of the inspectors was only present for day two of our inspection.

We were unable to request a provider information return as the inspection was in response to serious concerns. During our inspection we looked at care plans and risk assessments for six people, four staff recruitment files, accidents and incidents records, policies and procedures, records of audits which had been carried out in the last 12 months, safety certificates and daily care records.

Before our inspection we reviewed the information we held about the service including notifications of incidents that the provider had sent us since the last inspection. We contacted local commissioners of the service, Healthwatch and the local safeguarding team to request information.
We spoke directly with six people who lived at the service, three visitors to the service, six care staff, one domestic and two members of staff brought in from another organisation following our concerns

Inadequate

Is the service safe?

Our findings

One person told us staff "are all right you upset them sometimes they get a bit voicey." One person told us "some staff speak to me in a way I don't like." We informed the local safeguarding team of these allegations, who conducted an investigation.

We spoke to staff about their understanding of safeguarding. Although staff were aware of safeguarding and knew signs of abuse to look out for we found from our inspection findings that staff had not acted to protect people from harm of abuse. During the inspection we saw two incidents of concern the first was a hoist being used incorrectly which put the person in the hoist and the staff at risk of harm. The second incident involved a person with behaviour that challenged the service where staff did not know how to work with the person safely to deescalate the challenges posed and the person subsequently became aggressive towards staff and other people. We reported these to the local safeguarding team. This meant that someone external to the service will look at the issues we have raised. When asked about any incidents of abuse staff told us "I would not know about that at my level." Another reported "that's confidential only the management would know about that." Staff told us if they were concerned about anything they would report it to the manager or the deputy manager. One member of staff told us "they [the manager or deputy] would decide if an incident or accident form needs to be filled in. We spoke to six members of staff who all told us they had received safeguarding training in October 2015. We could find no evidence of this. This meant we could not be certain that staff had the relevant training to keep people safe from harm and abuse.

We looked at accident and incident reports going back to 2014 and found that there had been 12 incidents which should have been recognised and reported as safeguarding matters, but had not been. We discussed this with the senior career who told us "management would do that it's not something we deal with." This comment alledged that oversight of safeguarding incidents at the home was not in line with expected standards.. For some accidents and incidents we found notes in daily care records but no corresponding accident or incident form.
The above examples demonstrate that the provider had failed to protect people from abuse. This was a breach of Regulation 13 (1) safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that there were risk assessments in each person's care plan however these had not been regularly updated and did not reflect current risks. In one person's Malnutrition Universal Screening Tool (MUST) it stated they needed a soft diet and a weight boosting diet; however no risks had been identified. In another example one person required a Zimmer frame to walk, this was documented in their risk assessment however we saw them walking without it. When a member of staff was asked about this they did not know that a Zimmer frame was in use for that person.

Personal Emergency Evacuation Plan (PEEP) is a document which details the safety plan, e.g. route, equipment, staff support, for a named individual in the event the premises have to be evacuated. These were in place and stored in a grab bag. However the list of residents was not accurate. The profile for each

person was not updated with some dated 2012.There was no accompanying documentation of people's needs. This meant that in an emergency staff would have no clear guidance on how to help people evacuate the building. We asked the senior on duty to update this list. We also requested that a fire officer attend the Laurels to check that staff knew how to evacuate the building in the event of a fire.
This was a breach of Regulation 12 (1) safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the home was not clean bathrooms had visible dirt on taps and floors. Toilets and clinical waste bins were soiled with faeces. One bathroom had a cracked bath panel which was dangerous. One bathroom had no Personal protective equipment (PPE) such as aprons or gloves for staff to use. This meant people were not protected from the risk of infection because appropriate guidance had not been followed.

We found the conservatory was used as smoking room and was dirty with lots of used ash trays around. We found the dining room floor was dirty as were tables in the dining room. The Kitchen was dirty with food debris on floors and counters. The boiler in the kitchen was tied up with string. We found food stored in a cupboard in a bathroom. Some food in the fridge was out of date. We asked that this be removed on 22 February it was still there on the 23 February. We asked staff to remove it whilst we were there.

We saw a stair lift however this was not in use. The senior career did not know if any plans were in place to repair it. The passenger lift had not had regular six monthly testing this meant we could not be sure the lift was safe. We referred this to the local environmental health agency because of our concerns.

We found that there was no suitable legionella risk assessment in place and tests had not been carried out. Legionnaires' disease is a potentially fatal form of pneumonia and everyone is susceptible to infection. The risk increases with age but some people are at higher risk including people over 45 years of age people suffering from chronic respiratory or kidney disease diabetes, lung and heart disease anyone with an impaired immune system. Legionella and related bacteria may be found in purpose-built water systems such as cooling towers, evaporative condensers, hot and cold water systems. This should be monitored by recording water temperatures regularly and having an assessment carried out at least yearly.

We found that many hot water taps in bathrooms and bedrooms did not get hot water however several ran extremely hot. We discussed this with staff who told us "in this bathroom there is a trick turn on the cold tap in the sink and the hot water tap in the bath for hot water. Staff who have been here a while know this." Another member of staff told us "I get a bucket of hot water from the sluice to make a hot bath for people." We asked the provider to instruct the services of a plumber in light of our concerns and the plumber explained to us "the boilers are on an old system in order to get hot water the first tap in the line needs to be turned on then hot water will run to all taps."

This was a breach of Regulation 15 (1) premises and equipment of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We found eight people attended the Laurels for day care or respite these people had no care plans or risk assessments in place. This meant staff would not know how to care for these people putting both the people and staff at risk of harm.
This was a breach of Regulation 12 (1) safe care and treatment of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We saw the administration, storage and disposal of medicines was not safe. On the first day of our

inspection we found an unsecured box containing medication in a flat above the first floor. Medication was being dispensed from this box. The door to the flat was not locked this medication could have caused significant harm to a person if they had taken it. We took this medication to the senior career who reported it was to be returned to the pharmacy by the handy man. The handy man had no knowledge of this. We took the box to the senior career and asked that it was stored in the correct manner in a locked cupboard.

We found people requiring as required (PRN) medications had no protocols in place this causes a risk these medicines might not be properly administered to people. Having a protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner.

We found that the controlled drug register contained numerous numerical errors which would have been picked up by an audit had one been in place. We also found medication not being given as prescribed. We found none of the medicines we checked could be accurately reconciled with the amounts recorded as received and administered. This demonstrated the home did not have good medication governance.

Staff told us if someone was unwell and required medical attention, they "had to ask the manager or deputy before making a call to medical services including 999 calls this meant that people's health was put at risk as medical advice was not sought in a timely manner .
This was a breach of Regulation 12 (2) (g) safe care and treatment of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We found that the recruitment which had taken place was not always safe or up to date. We looked at the recruitment processes which were in place. We found one member of staff had a reference from a relative who worked in the home. Staff had disclosure and barring service (DBS) check to ensure that people were suitable to work with vulnerable people. Some staff had these in place from other employers. The checks were not updated regularly. One was dated 2002. When people had changed their name this had been handwritten on the original form. Although it is not mandatory that these checks are renewed, the provider was unable to confirm that on going suitability of staff is routinely monitored and verified to ensure they remain suitable to work with vulnerable people. We discussed this with the manger, who was brought in on the second day and asked that these checks were updated for all staff.

This was a breach of Regulation 19(1) (2) Fit and proper persons employed of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People told us the food at the home was good one person said "I love the food look, forward to tea." Another person said "I love the home cooking."

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and specifically on the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. 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 the least restrictive option 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 procedure for this in care homes and hospitals is 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.

We looked at the records in relation to Deprivation of Liberty Safeguards (DoLS), which are measures which need to be put in place to protect the rights of people who have been assessed as not having capacity to keep themselves safe and need to be restricted to maintain their safety and well-being. We found that a large number of the people who used the service had some level of cognitive impairment. People had not been assessed to gauge what decisions they were capable of making and whether a best interest decision was needed to keep them safe and whether DoLS needed to be in place. We saw that no one in the service had the correct DoLS authorisations in place.

We saw people were being deprived of their liberty at the service as the home had a locked door; there was a key pad in place on the front door. Some people living in the Laurels lacked capacity to make this decision however no capacity assessments had been made. One person was cared for in bed with bed rails, who the inspector saw lacked capacity however no capacity assessments were in place. We saw documentation for three people describing them as being under 24 hour supervision and not being allowed to leave should they choose to do so. This showed that the manger and staff were not aware of their responsibilities under the mental capacity act 2005 (MCA)
In the care files we looked at we saw that consent to care had been signed by key workers or relatives there was no evidence that people did not have the mental capacity to sign for themselves and no assessment of their mental capacity in their records . This showed that staff had limited understanding of mental capacity and how decisions might be made in someone's best interest if they lacked capacity.

We saw that four rooms were occupied by two people. The people in the rooms had not signed any paper work to say they had consented to sharing a room and there were no capacity assessments in their care plan

These examples demonstrate a breach of Regulation 11 (1) need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the only choice we saw offered to people were as in relation to their meals there was a choice of two options at lunch time. During the inspection we saw occasions when choice was not offered and documentation that showed a lack of choice. For example saw task lists documented for each shift. The night shift list stated "10pm cup of tea given to residents still up." "5.30 am early risers may be got up. Early risers may be those who need toileting." A member of staff told us "night staff get everyone up." One person told us "I wake around 5am they have to get everyone up as they are too busy." We saw a document titled "day staff working instruction" this listed "8am help remaining service users to rise, 8.15 breakfasts is served, 9.15 two carers to do two baths." "11am juice to be given to all service users." We spoke to a staff member who informed us they had not bathed any one today and reported "I will see who's due." One person told us they" had a bath "weekly whenever they [staff] can."

We observed that at lunch all service users in the dining room were given water to drink, no alternative choice was offered. We observed hot drinks being given to people in the lounge, no individual choice was offered, or individual options for milk or sugar.

We observed mealtimes during our inspection. We saw not all staff were involved in the service of meals. The day shift list confirmed that as lunch was served two members of staff were to take their break. This meant a lack of staff available to help people with their food. We saw that staff did take their breaks as food was being served. This meant that there was only one member of staff in the dining room to assist people with their food and one member of staff in the lounge. who required assistance were given their meals in the lounge and remained sat in arm chairs. One member of staff offered assistance to five people in the lounge on a one by one basis.

In the dining room people were offered a choice of meal. However there was only one member of staff serving food which led to some people sitting for a long time before their food arrived.
One person's care plan stated they required a soft diet. We observed them being given Yorkshire puddings. We discussed this with a member of staff who was not aware of this. One person was cared for in bed. We looked at the food and fluid chart in their room and saw that at 3pm on 22 February the only food documented was in the dinner column with no time or signature. The person was diabetic .This could have caused a drop in blood sugar which is dangerous for people with diabetes. This demonstrated that people's food and fluid intake was not being monitored.
This was a breach of Regulation 14 (1) meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not provided with the guidance and training to carry out their role effectively. One member of staff alleged examples of unprofessional behaviour by management "if they didn't like what we are doing." Staff reported that all their mandatory training which included moving and handling safeguarding vulnerable adults and the mental capacity Act, had taken place in October 2015 however no documentation was found in relation to this. The last recorded training was dated 2014.This meant we were unable to assess if staff had the appropriate knowledge and skills to perform their job roles. The staff we spoke with had received training but it was clear from our conversations that they didn't understand how to implement their learning.

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We found that supervision was not effective or robust. Staff told us they had regular supervision however, supervision notes for the four people we looked at were documented as being just 15 minutes for each session and were very sparse. There was no evidence of any training needs being identified, or any

meaningful discussion regarding working practice. This showed that staff were not receiving regular management supervision to monitor their performance and development needs

On the first day of our inspection we saw a person who had fallen the previous evening the day staff called the GP this showed that health care professionals were not called as quickly as they could have been causing a delay in receiving treatment. During our inspection we saw a district nurse come in to see people. One visiting professional told us they were called "appropriately and came in to the home regularly.

Inadequate

Is the service caring?

Our findings

One person told us "sometimes you upset the staff when you are a bit down." One person alleged "Sometimes I go off my food staff makes me eat." One relative told us "the manager can't be too compassionate they are the manager. "One person told us "the manager keeps themselves to themselves they have to do what they want to do." One person alleged unprofessional behaviour of the senior management at the home and added "but we have to respect that." . We reported these allegations to the local safeguarding team and the owner of the Laurels in order for them to investigate.

One member of staff alleged, that when people were given gifts of sweets and chocolate they were taken by the senior management of the home and locked away. It was further alleged that the senior management would then decide if people were allowed access to their gifts. We saw the gifts in boxes labelled with people's names in the pantry. There was no documented reason why these gifts were locked away for all residents.. We discussed this with the staff who were brought in to manage the home during our inspection and they ensured each person had their gifts returned to them. These concerns were also reported to the local safeguarding team for investigation.

Staff described allegations of further unprofessional behaviours which they said were exhibited by the senior management at the home which included allegations of undermining of staffs work in front of others. This staff alleged led to low morale amongst the staff team which they said had affected the way in which they cared for people.

A member of staff alleged the senior management at the home had acted in a controlling manner in relation to the gifts which had been allegedly withheld from people We reported this to the local safeguarding team for investigation.
A staff member alleged that one person's room was used for professional visits for every one living in the Laurels, and that the room had been used as a Santa's grotto at Christmas. There was no documentation of this in the persons file referring to this as an agreement so we could not be sure the person had consented to this. This demonstrated a lack of respect for people and a lack of regard for the person's right to a home life. We asked the manager brought in during our inspection to ensure this practice was stopped.

A staff member alleged that on occasion beds were moved around to allow extra people to stay overnight. When discussed with the senior carer we were told "the people lack capacity they don't choose to move, the manager chooses who will move."
We saw that the shared bedrooms had no division or separation in them this meant that people's dignity and privacy was not respected. We saw one person being taken to a toilet to have a shave mid-afternoon staff said "you haven't had a shave today come on" no choice was offered and he was taken to a toilet to shave rather than his own room or a bathroom. We saw two people with dirty nails and one person was shouting out for help to clean their nails. These examples demonstrated that staff had not taken the time to support people with their personal care in a way which would promote their dignity.

These examples demonstrate a breach of Regulation 10 (1) dignity and respect of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

We saw that staff were task orientated and little interaction took place between staff and people living at the Laurels, outside of the care being given. When care was being given staff were caring in their attitude and the conversations they had with people. However we saw no opportunity for staff to build relationships with people. We saw in care plans that people had not been involved in planning their care. Annual reviews took place with family members however these were very brief. The three reviews we looked at all stated the person "continues to enjoy living at the Laurels no changes necessary."

We saw that clocks in people's bedrooms were not at the correct time. This meant that people did not know the correct time of day or night Having clocks set at the correct time enables people with dementia to rationalise daily routines, for example, meal times.

We could not find any evidence of people in the service having access to advocates to help them make decisions with which they needed support. We asked staff about advocacy, staff were not aware of the need for advocates for people who did not have family to support them to make decisions.

Inadequate

Is the service responsive?

Our findings

One person told us "I used to knit but I don't do that anymore." One person told us "I have been on trips to Cleethorpes."

We saw that care was not person centred. We looked at people's care records and saw they lacked detail, contained conflicting information and did not provide a clear picture of the person they related to. We saw in several care plans under medical diagnosis the word confusion and in one the word morbiditus these are not medical diagnoses and showed a lack of understanding by the person filling in the forms. The lack of information, combined with the fact that some people had dementia and were not able to fully communicate their needs, put the people living at the Laurels at risk of inappropriate and unsafe care.

There was no record of people's likes and dislikes in people's care plans. This meant care staff would not know what was important to the people they cared for. We saw there was inaccurate information in the care records. For example in one person's file under equipment nothing was documented however we saw the person was using a wheelchair, and in the list of items brought in on admission was a Zimmer frame. We asked a staff member and they were unsure which was correct.

Another example showed a person needed a weight boosting diet in one entry and soft diet in the next. There was no evidence as to why these diets were required and staff were unaware of them when asked staff did not know that either were in the care plan. This meant that care staff were unable to understand people's needs and respond to them effectively. This lack of clarity could put people at risk of harm.

We saw that in care files there was a social profile this included people's religious beliefs whether they were married, any significant people in their life their favourite newspaper and T.V. shows and significant events in people's lives. In three files we looked at this was not filled in. Having detailed information about a person's life enables staff to have insight into people's interests, likes, dislikes and preferences. Life history can also aid staffs' understanding of individuals' personalities and behaviours.

We discussed the care plans and risk assessments with the manager who was brought in and agreed that all needed to be re written this would involve the manager and staff re assessing each person in order to get an accurate picture of their care needs likes and dislikes

We saw a plan of activities displayed in the reception area of the home; this was for the year 2016 and included a spring fair, trip to Bridlington and staff Oscars .People told us they had been to the seaside last year. There was no evidence of how the activities were chosen. One relative told us the manager puts on events throughout the year. There was no list of activities on offer daily. However an activities coordinator was in post and daily activities did take place. We observed a coffee morning with a quiz being held. People were not asked if they wanted to attend the quiz everyone was taken in to the dining room. The staff member holding the quiz was very enthusiastic and managed to keep peoples' attention. However everyone was taken to the dining room at 11 am and sat at the dining table from 11am until 1.30pm when

lunch was over. This was a long time for some people who became agitated at the table and we observed two people to be incontinent. This meant that people's needs were not being met.

One person who was cared for in bed was left with nothing to occupy them for long periods the only time staff went in the room was for care tasks. This can lead to social isolation and associated health complications. These examples demonstrate a breach of Regulation 9 (1) person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were unable to access the complaints records. The senior on duty during our inspection told us the management dealt with this. We were unable to find a policy on complaints. One person told us the manager "has to do what they want to do" and alleged unprofessional behaviour by the senior management of the home" We saw a handwritten note on the wall outside the dining room signed by the manger which stated "you have said the equipment is lacking be more specific." Staff told us this was due to concerns which had been raised about the hoists. they alleged that no action had been taken and staff said they had "said as much as they could." These allegations described a situation where the manger did not act on concerns that were brought to their attention.

Inadequate

Is the service well-led?

Our findings

People alleged the manager was "loud" another person alleged that the senior management at the home acted unprofessionally" Another alleged that they had become involved in altercations with the management at the home. One person reported "they get things done."
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. On the day of our inspection the both the manager and the deputy manager were on annual leave. There was a senior career in charge. Due to the level of concerns raised during our inspection we asked the provider to carry out investigations into the suitability of the management arrangements at the home. In order to do this the provider brought in a team of staff from another organisation to support the staff and people living in the Laurels.

We saw throughout our visits that there was no robust leadership of the staff who were working in the Laurels. Staff alleged that they were not empowered to make decisions, and had to refer any decision to the manger or assistant manager., For instance if a 999 call was required this had to be authorised by the senior management of the home. These allegations meant that staff were unable to offer care in a timely manner which could have caused unnecessary risk to the people living in the Laurels. These allegations demonstrated a leadership style that did not give staff confidence to make important and potentially urgent decisions.

We found the systems in the home for managing records were poor, daily notes were kept for the current week in a file and then transferred to plastic wallets. This meant that People were not protected from the risks of unsafe or inappropriate care and treatment because recent contemporaneous notes were not stored in one place for staff to access. We found record keeping was of a very poor standard, with daily records not giving vital information about the care which had been given or the well-being of the person they were written about. We saw one person's daily which simply said "wondering ++++." Another person's notes stated "good diet taken" and "sleeping ++++"This meant that visiting professionals could not see what had happened with people they were visiting, for example whether they had been unusually sleepy or confused .

We saw that staff meetings had taken place every month, however staff told us "I don't know why I attend nothing changes." "It's a waste of time." Staff surveys were in place and last filled in in February 2016. We saw that every form stated happy to work here no concerns. Staff alleged that they were not supported to express opinions openly. These allegations showed a lack of openness in the home and a culture in which staff found it difficult to express their views. We countered was no accurate record of any concerns or ideas staff may have had, as they had not been recorded. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and treatment for people living at the home.
We asked to look at the auditing which had taken place over the past 12 months. No audits could be found. This demonstrated the home had no effective quality assurance and governance systems. This meant the

management did not have oversight of the care being provided meaning that people were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

Policies and procedures were not reviewed and were outdated. The policy on restraint was dated 1996 and did not reflect current guidelines. There was a whistleblowing policy in place however this gave no details on how staff should raise concerns about the manager of the home or who they would contact with any concerns about the management. Reviewing policies enables registered providers to determine if a policy is still effective and relevant or if changes are required to ensure the policy is reflective of current legislation and good practice.
These examples demonstrate a breach of Regulation 17 (1) good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there was significant evidence that the provider had failed to notify the Care Quality Commission of incidents which had taken place, which under the terms of their registration they had a duty to report, this included serious injuries where fractures had occurred. There was also evidence there had been a large number of incidents where people with behavior that challenged other people had hurt other people in the home and these incidents had not been reported correctly. This meant the manager was not being open and transparent when incidents had occurred.
This demonstrates a breach of Regulation 18 (1) notification of other incidents of the Care Quality Commission (Registration) Regulations 2009: