SHC Rapkyns Group Limited

The Laurels

Inspection report

Guildford Road
Broadbridge Heath
Horsham
West Sussex
RH12 3PQ

Tel: 01403220770

Date of inspection visit:
15 August 2018
21 August 2018

Date of publication:
07 July 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced focused inspection of The Laurels on 15 and 21 August 2018.

This inspection was carried out in part in response to concerns shared with us by the local authority, West Sussex County Council (WSCC) Adult Safeguarding team. These concerns related to unsafe care and risk management of specific individuals', bowel care, nutrition, hydration, behavioural, wound management, postural support and on-going healthcare need

The inspection was also undertaken in part in response to review and analysis of information we had received about the service via our on-going monitoring and inspection processes. This information indicated that all people at the service may be at risk due to on-going unsafe management of medicines.

Following the last inspection on 20, 21 and 24 June 2018 the provider was not meeting multiple legal requirements. At this inspection we checked that improvements had been made to meet some of these requirements which related to the information of concern we had received. The requirements that we checked to see if they had improved were regarding; managing risks to people, management of medicines, deployment of suitably trained staff, preventing and learning from safety incidents, safeguarding people and operating effective governance frameworks and quality assurance systems.

We inspected the service against two of the five questions we ask about services: is the service well led and is the service safe. No urgent risks were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them.

The Laurels is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided.

The Laurels is registered to provide accommodation, nursing care and personal care, treatment of disease, disorder or injury and diagnostic and screening procedures. The Laurels is registered to provide this support for up to 41 people and younger adults with a learning disability or autistic spectrum disorder, physical disabilities and sensory impairments.

The Laurels is situated in a rural part of West Sussex on a self-contained complex. The service is separated into four different areas called 'Lodges'; Juniper, Cherry, Birch and Aspen. At the time of the inspection there were 19 people living at The Laurels; 10 people in Cherry, four people in Birch and five people in Juniper. Aspen Lodge was closed and there were no people living there.

People have their own bedrooms and each Lodge had its own lounge and dining area. All people living at The Laurels also have access to a communal lounge, gym, computer room, spa-pool, swimming pool and sensory room.

The Laurels had been built and registered before Registering the Right Support (RRS) had been published. The provider had not developed the service in response to the values that underpin RRS or changes in best practice guidance for providers of learning disability and autism services. These values and guidance includes advocating choice and promotion of independence and inclusion, so people using learning disability or autism services can live as ordinary a life as any other citizen.
We found The Laurels did not always conform to this guidance and values when supporting people or in the model, scale and geographic setting of the service. Due to this, it is unlikely that a request to register The Laurels today would be granted.

The Laurels has been without a registered manager since 10 April 2018. A registered manager is a person who has registered with the CQC 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. The service had recruited a manager to permanently fulfil the registered manager's role at the beginning of June 2018. The manager was in post and in the process of formally registering with the Care Quality Commission (CQC).

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

Between May 2017 and July 2018, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find. We used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection.

We last inspected the Laurels on 20, 21 and 24 June 2018. We carried out a full comprehensive inspection of the service. The service was rated 'Inadequate' and we identified multiple breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014 regulations.

These breaches regarded; failures to keep people safe from abuse and improper treatment, provide safe care and treatment, operate effective governance frameworks and quality assurance systems, provide person centred care to people, treat people with dignity and respect, provide care and treatment with the consent of relevant people and deploy sufficient numbers of suitably skilled and experienced staff.

The service was also in breach of the Care Quality Commission (CQC) (Registration) Regulations 2009 regarding failure to notify the CQC as required regarding allegations of abuse in relation to service users.

We found urgent and serious evidence of abuse, unsafe and improper treatment and on-going high risks for some people who could display behaviours that could be physically challenging living in a part of The Laurels called Aspen Lodge. We also found urgent and serious risks of harm presented to all people living at The Laurels presented by unsafe management of medicines.

Due to the serious and urgent nature of concerns, after the inspection we issued a Notice of Decision (NoD) to the registered provider on 26 June 2018. The NoD told the provider to act to review the management of their medicines and make sure people living in Aspen Lodge were supported by sufficient, suitably trained staff. We also told the provider that they should not admit any new people to live at The Laurels without permission from the CQC. Shortly after the NoD was issued, the provider temporarily closed Aspen Lodge.

Following the issue of the NoD, after the report was published for the inspection on 20, 21 and 24 June 2018,

the service was rated as Inadequate overall, requiring improvement in the key questions 'Caring' and 'Responsive' and Inadequate in 'Safe', 'Effective' and 'Well-Led'. This was the second time the service was assessed as 'inadequate and therefore the Laurels remained in special measures. Services in special measures are kept under review and inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

During this focused inspection we found concerns consistent with the information shared with us by the local authority safeguarding team regarding poor record keeping, information sharing and risk management relating to specific individuals' bowel care, hydration, postural, wound management and on-going healthcare support needs. These concerns meant people were at a high risk of potential harm.

Where people at risk of constipation had identified actions to manage risks if they did not have a bowel movement, this was not always monitored effectively. When action was needed after periods they had not had a recorded bowel movement, such as giving them medicines or seeking medical advice, this was not always done.

Systems in place to monitor people's vital health signs to help warn staff that they may be unwell and require medical assistance were not operating effectively. Staff were not always recording or analysing information about vital health signs correctly, so did not always know if a person was unwell or needed assistance. Where signs showed a person was unwell and needed further medical help, staff were not always acting to do this.

People requiring support to take fluids and were at risk of dehydration had not always been assessed to know how much fluid they needed to have each day to manage this risk safely. Where people had been assessed as needing certain amounts of fluids every day, it was not always recorded that they had received enough to drink to keep them safe.

People requiring support to move and position their bodies due to physical disabilities had several conflicting guidelines for staff to follow to know how to safely manage risks associated with this, such as pressure wounds. Staff were not all following the same advice and the person was being supported in different ways. This meant it was not known if the person was being supported to manage their risks associated with their body positioning needs safely.

It was not always recorded when people had been supported to have their medicines. Staff had missed giving some people their required medicines. Stocks of medicines were not always recorded accurately. This represented an on-going risk that people could not receive their medicines safely or as intended.

We also found the provider had not taken effective action to improve the service in relation to managing risks to people, providing safe care and treatment, safeguarding people from abuse, safe management of medicines and operating effective governance frameworks and quality assurance systems.

The quality and safety risks and governance issues found during this inspection corresponded with themes of concerns and breaches of regulatory requirements in our inspection processes dating back to November 2017. The provider's governance framework had not always ensured that staff at all levels understood and had carried out their responsibilities successfully.

Staff and management had not always identified outstanding risks to people that we found during this inspection. Where they had been identified, action had not always been taken to manage risks safely. When

incidents had occurred where people's safety could be at risk, this was not always reported internally or externally by staff at the service. This meant adequate reviews, investigations and sharing of information either within the service or with partnership agencies had not always taken place. Opportunities for lessons to be learnt or actions taken in response to incidents had not occurred and people continued to be at risk of abuse and improper treatment.

Following this focused inspection, we wrote to the provider we wrote to the provider to tell them what action we were proposing to take should the serious concerns not be addressed immediately. The provider was invited and put forward a response within 24 hours setting out how they had, or how they intend to address the concerns immediately. Following receipt of these reassurances, we visited the service for the second day of inspection to review the implementation and progress of the provider's actions. Immediate action had been taken to lessen the risks to people requiring PEG, behavioural and hydration support. Actions were in place and further evidence provided about forthcoming actions to ensure the safety of people requiring bowel care and NEWS support and improve their quality assurance processes.

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

The rating for the key questions 'Safe' and 'Well-Led' are inadequate and the overall rating for this service remains 'Inadequate'. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection. The service therefore remains in special measures. For adult social care services the maximum time for being in special measures will usually be no more than 12 months.

This service will 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 so there is still a rating of inadequate for any key question or overall, we will act to prevent the provider from operating this service. This will lead to cancelling or varying the terms of their registration.

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.

Risks to people were not being managed safely.

People were not always protected from abuse and unsafe treatment.

Medicines were not always managed safely.

Accident and incidents were not always reviewed to learn from and look at how to prevent them from happening again.

Premises were clean and hygienic and people were protected from risks of infection.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance and governance systems were not operating or being managed effectively.

Risks and quality issues at the service had not always been identified or acted on.

Statutory notifications had not always been submitted as required.

The service did not always work in partnership with other agencies in an effective way.

Systems and processes had recently been introduced to involve staff, people and relatives in developing the service.

The Laurels

Detailed findings

Background to this inspection

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

This inspection took place on 15 and 21 August 2018 and was unannounced.

On 15 August the inspection team consisted of three inspectors and a specialist advisor with specialist experience in nursing. On 21 August the inspection team consisted of three inspectors.

For this inspection we did not request a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information we held about the service. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events the provider is required to tell us about by law. This is necessary so that, where needed, the Care Quality Commission (CQC) can take follow up action.

During the inspection, we spoke with four support workers, one agency support worker, four registered nurses, two agency registered nurses, two team leaders, an internal quality officer, the organisations' autism specialist, the service manager and the area manager.

We 'pathway tracked' five people using the service. This is where we looked at people's care documentation in depth, and obtained their views on how they found the service where possible. This allowed us to capture information about a sample of people receiving care.

We spoke with two people's relatives and two people. We observed people's support across all areas of the service.

During the inspection, we reviewed other records. These included staff training and supervision records, staff recruitment records, medicines records, care plans, risk assessments, and accidents and incident records. We also reviewed quality audits, policies and procedures and staff rotas and information.

Inadequate

Is the service safe?

Our findings

At this inspection we found the provider was continuing to fail to protect people from abuse and avoidable harm and the service remains 'Inadequate'.

At the last inspection in June 2018, we had identified the service was not managing risks to people safely. We also identified the provider was not managing medicines safely, preventing and learning from safety incidents and people were not protected from abuse and improper treatment. The provider continued to be in breach of Regulation 12 and 13 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014.

At this inspection, we looked at the individual concerns in each of the topic areas of concern raised with us by WSCC. We also looked to see that improvements had been made since the last inspection to meet the breach of legal requirements.

At the last inspection we found guidance for staff to manage risks of constipation were not detailed enough. Recording and monitoring of bowel movements for people at high risk of constipation was inconsistent and ineffective. This meant staff could not know how to safely support people to meet their needs, leaving them at risk of harm. At this inspection, we checked to see if people were at risk of harm and if the service had made the necessary improvements for people requiring support with their bowel care needs.

We found there had been some improvement in the risk management guidance available for staff. Recording of people's bowel movements was more consistent. However, staff were not always aware of or were following the guidance and directions for all people at risk of constipation. This meant people were at high risk of harm. For example, one person's bowel movements were monitored daily. They had risk management guidelines saying if they did not have a bowel movement for more than three days, staff should give them when required (PRN) medicines and seek further medical attention. The person regularly went home for more than three days and staff were directed to ask the person and their parents about their bowel movements while they were at home and record this information. This would allow staff to know how long it had been since their last bowel movement when they came back to the service and if any further support was needed.

The person's monitoring records showed that had not had a recorded bowel movement for more than three consecutive days on eight occasions since the start of the year, for periods ranging from four up to 11 days. The person had been at home for more than three days for some of these periods. However, there was no record that staff had asked about the person's bowel movements while they were away. We saw the person returning home after more than three days away during the inspection and that their bowel chart had already been completed as 'No Bowel Movement' for the periods while they were away. Without knowing whether they had opened their bowels at home, it would be difficult to know how many days in total they had not opened their bowels. On return to the service, there were periods up to 7 days on more than one occasion where no bowel movement was recorded. For all these periods where no bowel movement was recorded for more than three days, it was not recorded that staff had acted to seek further medical advice.

The person's medication administration record (MAR) showed that they had not received PRN medicines as directed for these periods.

At the last inspection we found that the provider was failing to ensure that risks associated with people's nutrition and hydration support needs were being managed safely. Some people required a percutaneous endoscopic gastrostomy (PEG) tube. This is a tube that is inserted into a person's abdomen so they can receive liquid food, fluids or medicines directly to their stomach. Records to show people had been supported to have the correct amounts of fluids and medicines via their PEG, had not always been completed. PEG equipment and entry sites had not always been recorded as having been maintained and cleaned as directed. This meant it was not known if people were having their needs met and this left them at high risk of harm.

At this inspection, we reviewed the management of risks associated with individuals requiring support with nutrition, hydration and PEG tube, to see if the provider had made the necessary improvements.

People had guidelines for staff to clean the site of the PEG tube entry into the stomach every day. However, this was not recorded for some people and only inconsistently recorded for some others. This increased the risk of these people coming to harm caused by inflammation and infection. People had guidelines in place to rotate the PEG tube at the site of entry to the stomach every seven days to further reduce the risk of inflammation and infection. Records showed that this was not always done. For one person this failure had resulted in their PEG entry site becoming "red and sore" and they had been prescribed medicated cream to alleviate these symptoms.

Some people with a PEG and some people who required support to take fluids orally had been assessed as being at risk of dehydration. These people's risk management guidelines stated they should have a recommended daily amount (RDA) of fluids. Staff were directed to support them to receive, record and monitor their fluid intake, to ensure they received their RDA. Staff had to alert nurses or other healthcare professionals if concerned the person was not achieving their RDA.

For some people with a PEG and for some people who required support to take fluids orally, guidelines did not always say what their RDA of fluids should be. Staff were not always aware of what people's RDAs should be. One staff member said, ""I'm not sure what [name]'s daily amount of fluids should be. Do you know how I should work it out?". People's fluid intake records had not always been completed. Where they had been completed and where there was a RDA in place, not all entries showed people had received their RDA of fluids. People's daily notes did not record that any concerns had been raised when people had not been supported to receive their RDA of fluids, or that any action had been taken in response. This increased the risk that people may suffer harm due to becoming dehydrated or that staff may not recognise this and seek medical assistance.

Staff used a standardised system for recording and assessing baseline observations of people's health indicators. This included temperature, pulse, blood pressure and respiratory rates. The system was called National Early Warning Score (NEWS). NEWS was designed to ensure that people's health needs were effectively monitored and, if necessary, people could be supported to receive or access healthcare support and services quickly.

At the last inspection we found that NEWS systems in use at the service to monitor people's health needs were not effective. This meant there was a risk that deterioration of people's physical health may not be identified and that people would not be supported to receive or access healthcare services in a timely manner. Following the last inspection, we recommended that the service sought support and training from

a reputable source and acted to ensure NEWS systems are implemented and utilised effectively. At this inspection we looked to see if the provider had made necessary improvements to manage these risks and acted on the recommendation.

For some people, their NEWS information had not been consistently completed. There was inconsistent guidance for staff to follow when completing the NEWS. There had been no consideration of establishing individual baselines of people's normal health indicators, outside of the generic recommendations on the NEWS. This is recognised as good practice as people's individual baselines may vary according to their personal health conditions. Without this guidance, there is an increased risk that warning signs may not be identified effectively.

Not all staff understood how to record and analyse the information on the NEWS, including how to score and understand the results. This meant staff could not effectively assess what had been recorded to see if further healthcare support was required. Where people's NEWS had been completed and scored and the results showed that action should be taken to seek further medical attention, this was not always done. This placed people at high risk of potential harm.

For example, for one person, staff recorded an increased NEWS score of 3 as their vital signs for temperature and oxygen saturation indicated they may be unwell. The person's records showed that staff noted the person bleeding occasionally from their mouth area after this score was recorded. The NEWS guidance stated for an increased score of 3 compared to the baseline (of which there was no baseline to refer to) then observations should be repeated and 999 should be called. There was no record that either of these actions were taken, or that a GP or Nurse was alerted for further medical advice.

At the last inspection we identified that a person with physical disabilities who needed support to position their body were not having their needs met and had suffered a minor skin tear injury and reduction in quality of life. At this inspection, we reviewed management of postural and wound management risks associated with individuals. We also checked to see if the provider had made the necessary improvements in this area.

We did not find evidence that people were not being safely supported with wound management needs. Where necessary, people had been assessed and had guidelines about their postural support. However, some people had several different risk assessments and care plans all containing different and, in some cases, conflicting advice. For example, for one person, there were directions in some of their plans that they must be supported to move position every four hours and that this be monitored and recorded. In other plans, the directions were to move them less regularly. Staff were not sure which advice was the best for the person. The person's records of how often they were being moved showed staff were following different guidelines and moving them at different intervals each day. This meant it was not known if the person was having their needs met safely and placed them at increased risk of avoidable harm.

The failure to do all that is reasonably practical to mitigate risks and provide safe care and treatment to service users is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we identified people's needs and management of risks associated with their behaviours were not being met safely and in the least restrictive way. We had specific concerns that people living in Aspen Lodge who displayed behaviours that may physically challenge themselves and others were at risk of unsafe care, abuse and improper treatment. We told the provider to act to make sure there were enough staff with the right skills and experience to do meet these people's needs safely.

At this inspection, we checked to see if the provider had made these necessary improvements. We also looked to see if risks were being managed safely for other people requiring support with behaviours that may challenge.

Following the last inspection, the provider had temporarily closed Aspen Lodge. The provider took this decision voluntarily as they could not make the immediate improvements necessary to safely meet all people living at Aspen Lodge's needs or protect them from abuse. All people living in Aspen Lodge who required high levels of support with behaviours that may be physically challenging had moved out of The Laurels. Some people remained living in other areas of The Laurels who required support to manage risks associated with forms of behaviours that may challenge. These included potential and actual risks of emotional distress, anxiety and agitation, loud noises and self-harm.

An internal 'Autism Lead' from the organisation had been deployed to support staff understanding and best practice ways of working with people who remained living at the Laurels with autism and who could display behaviours that may challenge. This included promoting and coaching staff about Positive Behaviour Support (PBS) approaches, writing specific PBS plans and providing improved communication tools for staff to engage with people with challenging behaviour support needs more effectively. Current best practice guidance advocates a Positive Behaviour Support (PBS) approach when supporting people who may display or be at risk of displaying challenging behaviour. PBS is a holistic, person-centred approach to supporting people with a learning disability and/or autism. PBS promotes preventative and positive interventions from staff to help avoid the need for using reactive and restrictive practices. This enables people to enhance their quality of life and learn new skills to replace the challenging behaviour.

However, this work was still underway. Current practice and guidance for staff supporting these people who could display challenging behaviours focused on reactive or restrictive approaches. PBS plans and communication tools had yet to be completed for people and the Autism Lead had been unable to commit to working with staff for long enough periods to help embed their understanding of PBS and how to support people in line with PBS principles. This increased the risk that staff would not know how to meet people's needs and manage risks associated with their challenging behaviours safely and in line with best practice guidance.

For example, one person requiring support to safely manage behaviours including agitation and self-injury. There were behavioural support plans which gave guidance such as monitoring of behavioural incidents and de-escalation techniques to help manage these risks. However, details in the support plans, including suggested de-escalation techniques were brief and risk management guidelines for behaviours that may challenge remained focused on reactive approaches, such as removing the person from the room and supporting them to take a shower. The person's behavioural monitoring charts record 18 incidents of them self-injuring by hitting or banging their head between March and August 2018. On two occasions this resulted in them having nosebleeds.

No further action was taken in response to these incidents to holistically review the root causes of the challenging behaviour or the effectiveness of the de-escalation techniques. Information about these incidents was not shared externally for further review with health or social care professionals to explore how future risk of harm could be lessened. This left the person at increased risk of on-going harm and distress and an on-going reduction in their quality of life.

The failure to do all that is reasonably practical to mitigate risks and provide safe care and treatment to service users is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the first day of the inspection due to our serious concerns about the safety of people's bowel care, PEG, hydration, NEWS monitoring and behavioural support we wrote to the provider to tell them what action we were proposing to take should the serious concerns not be addressed immediately.

The provider was invited and put forward a response within 24 hours setting out how they had, or how they intend to address the concerns immediately. Following receipt of these reassurances, we visited the service to review the implementation and progress of the provider's actions. Immediate action had been taken to lessen the risks to people requiring PEG, behavioural and hydration support. Actions were in place and further evidence provided about forthcoming actions regarding ensuring the safety of people requiring bowel care and NEWS support.

At the last inspection we identified systems and processes to safeguarding people from abuse had not been effectively implemented. At this inspection we checked to see if the provider had made necessary improvements to ensure that systems and processes to safeguard people from abuse were effective.

Staff had received safeguarding training and there had been consistent communication and support for staff about how to use a recently implemented accident, incident and safeguarding reporting system. Where incidents had been reported, these had been subject to a more comprehensive system of internal management review, which had been designed to help identify learning and put in place preventative actions to take moving forward.

However, not all accident and incidents and safeguarding concerns had always been reported internally or externally by staff, nurses, service management and the provider's internal higher management and quality assurance teams. Not all staff we spoke with understood their responsibilities to raise concerns, record safety incidents, concerns or near misses. For example, where records showed that possible neglect may have taken place regarding staff not following risk management guidelines for people's bowel care and PEG needs and NEWS monitoring, this had not been reported internally by the staff and registered nurses, or reported externally by service and higher-level provider management. This meant adequate reviews, investigations and sharing of information with partnership agencies had not always taken place. Opportunities for lessons to be learnt or actions taken in response to incidents had not occurred and people continued to be at risk of abuse and improper treatment.

The failure to ensure service users were effectively safeguarded from abuse and improper treatment is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last inspection we identified that the provider was not ensuring the proper and safe use of medicines. Due to the level of concern we had a we told the provider to act to make sure medicines were being managed safely by seeking specialist advice from a pharmacist and acting on their recommendations. Prior to this inspection we had received notifications from the provider about errors that suggested people may be at risk of harm when being supported with medicines. At this inspection, we checked to see if the provider was meeting had made necessary improvements and if medicines were being managed safely.

The provider had acted to employ an independent pharmacist and was awaiting the outcome of their audit findings. While they were waiting for the results of the pharmacist audit, the provider had implemented new systems for storage, recording, ordering, disposal of medicines. Registered nurses had received refresher training in medicine administration. An internal 'Quality Officer' from the organisation was temporarily based at the service to help the registered manager oversee the implementation of the new medicine system. Their role included carrying out specific medicine audits every week to identify any issues and work with staff to make sure these were resolved and did not continue.

However, these actions had not been effective in identifying, investigating and addressing continued issues relating to stock control, administration and recording of medicines. This represented an on-going risk that people could not receive their medicines safely or as intended. For example, people's medicine administration records showed that it had not always been recorded when some people had received their medicines. Stock control records for some medicines were not completed correctly. Internal audits and statutory notifications confirmed specific errors for individuals where some people had not received their medicines, including PRN medicines, as intended.

The failure to ensure the proper and safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection there were not always sufficient numbers of suitably trained and experienced staff to meet people's needs safely. There were high numbers of agency staff being used to fill vacant posts across all units of The Laurels. Agency and permanent staff did not always have the right skills, knowledge and experience to meet people's needs safely. At this inspection we checked to see if the provider had made necessary improvements to address this issue.

Since the closure of Aspen Lodge and subsequent reduction in numbers of people living at The Laurels, agency usage had fallen significantly. Permanent staffing levels were stable enough to allow for rotas to be written that provided a sufficient mix of experienced and skilled staff on each shift. Agency and permanent staff inductions and training had been revised to be more comprehensive. Agency staff were booked in advance, using staff who had worked regularly at The Laurels and were allocated to the same unit each time if possible. This helped staff to know people's needs and gain the necessary experience about how to support them safely. Staff told us they were well supported when on shift by senior staff and management.

The provider was in the process of a 'Service Review' at The Laurels. This is a process being initiated in all the providers' services to re-assess how staffing and other resources are currently allocated against people's individual support funding. The objective of the review is to identify and resolve any differences to ensure people's needs and outcomes are met safely and in the most effective way. The service review was still currently underway with no set timeframe for completion. Initial analysis had resulted in a reduction of staffing levels at The Laurels as it was assessed people were being provided with more support than they were being funded for. Staff raised concerns with us about the reduction in staffing levels leaving some people at risk of not meeting their needs.

We did not find any evidence to suggest people had come to direct harm due to the reduction in staffing levels. However, staff said although they did not feel current levels were unsafe, the current staffing levels were putting them under a lot of stress due to increased workload. One staff said staffing levels were, "Not unsafe…we are struggling". Other staff told us that due to the decrease in staff, sometimes they had relied on diverting some people's social 1:1 time to help support other people with tasks such as personal care. Staff had raised this issue with the manager. The manager had restored previous staffing levels until the service review could be completed and staffing levels that met people's needs could be agreed and finalised.

The service employed separate cleaning staff and was clean and hygienic. Staff received infection control and used plastic gloves and aprons when supporting people with their personal care. Hazardous waste was managed appropriately. There were separate catering staff and both they and support workers received food hygiene training. This helped ensure food was handled and prepared safely. Health and safety and fire checks of the communal areas and people's rooms took place regularly. Maintenance issues were reported and action was planned and taken to address any issues. Equipment owned and managed by the provider

to support people, such as hoists and wheelchairs, had been regularly serviced and were well maintained.

There were safe recruitment practices. All staff had undertaken a satisfactory Disclosure and Barring Service (DBS) check before being formally offered a job. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting. Permanent staff had provided an application form, two references and passed an interview before starting work. Staff also had further training and an induction and probation period before being their position became permanent.

All nurses working at the service had a valid registration pin number with the Nursing and Midwifery Council (NMC). The NMC regulates nurses and midwives in the UK against their set standards of education, training, conduct and performance. A valid NMC registration helps ensure nurses have mandatory nursing knowledge, training and skills and uphold expected professional standards.

Agency staff employers were asked to provide the above information to evidence that any members of staff they were sending for shifts at The Laurels were safe and suitable to work at the service.

Inadequate

Is the service well-led?

Our findings

At the last inspection in June 2018, we had identified quality assurance systems and governance frameworks were not operating effectively. The provider continued to be in breach of Regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. The provider was found to be in breach of Care Quality Commission (CQC) (Registration) Regulations 2009 regarding failure to notify the CQC of incidents that had happened. At this inspection we checked what improvements had been made to meet these breaches of legal requirements.

Revised quality assurance and governance systems were in operation to ensure people received safe, high quality support. A more comprehensive and consistent auditing process by staff, management and the provider's internal quality team had been recently introduced. Reviews of audits created action plans, which prioritised tasks with set timeframes. Progress of these plans were overseen at local, middle and senior management level to help ensure completion.

However, although these changes had been made they were not always operating effectively and remained inadequate. Quality and safety risks found during this inspection had not always been identified by the provider's quality assurance systems. Where they had been identified, they had not always been acted on in a timely manner or monitored and managed effectively. The quality and safety risks and governance issues found during this inspection corresponded with themes of concerns and breaches of regulatory requirements in our inspection processes dating back to November 2017. The provider's governance framework had not always ensured that staff at all levels understood and had carried out their responsibilities successfully.

For example, issues regarding potentially unsafe management of PEG care and risks associated with on-going health monitoring have been identified as inadequate or requiring improvement in three consecutive CQC inspections since November 2017. Following the last inspection, a service improvement plan shows actions had been implemented to ensure PEG cleaning and rotation and support for people to have enough fluids was being carried out and could be evidenced.

Actions included regular daily reviews by staff, registered nurses and management to check PEG cleaning and rotation was done and records were completed. The provider's internal service quality improvement plan shows this action as having been signed off as completed by the location manager on 5 July 2018, and this had been seen and approved by the provider's area manager, internal quality team and higher management. However, this is not the case as our findings at this inspection show.

The failure 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 maintained and service performance was evaluated and improved is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There was not currently a registered manager at the service since February 2018. A manager had been

appointed in June 2018 and was fulfilling the role and responsibilities of the registered manager. The manager was currently in the process of applying to be registered with CQC. Prior to their appointment an interim area manager had been fulfilling the registered manager responsibilities. The area manager had continued to support the manager until the end of August 2018.

At the last inspection, we identified that all legal requirements of the service had not been met as expected, including submitting statutory notifications. Prior to this inspection, WSCC raised concerns regarding ineffective partnership working on behalf of the provider, including failure to share information to support safe care provision on behalf of people who use the service.

At this inspection we found that the registered provider's governance framework, had not ensured that the all legal requirements of the service had been met as expected. This included submission of CQC statutory notifications. For example, notifications had not been submitted to the CQC regarding allegations of abuse via neglect due to failure to monitor and manage risks in relation to people's bowel care needs.

The failure to ensure that all statutory notifications of incidents related to services of a regulated activity were submitted is a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Due to our serious concerns in relation to the failure to ensure effective partnership working, information sharing and operating quality assurance and governance systems, we wrote to the provider after the first day of this inspection to seek urgent reassurances about how these issues would be resolved. Following receipt of these reassurances, we discuss and reviewed this further during the second day of the inspection.

The manager recognised that these changes were necessary and acknowledged they were not consistently delivering an expected and adequate standard of care. They said that they were in the process of making changes but issues such as historical staff and management turnover and poor staff morale and standards of working meant this would take time. They said, "It is slow process, staff who have been here historically they are not used to being questioned, it is a change process and there is resistance".

The manager was committed to supporting staff to be able to deliver their vision of high quality person centred care for people. They had recently introduced more frequent formal and informal opportunities for staff to share necessary information about people's care with management and each other. These included more frequent daily 'walk arounds' and handovers to discuss people's support and any help identify and find solutions to any issues. Staff, people and relatives told us their opinions and input were being sought to help develop the service and identify areas of good practice to build on and areas to improve.

Additional staff training in areas where individual and service performance was currently inadequate had been arranged for all staff at the service. Staff meetings and supervisions had been re-designed and planned to take place more regularly. This would help highlight and aid staff understanding of their specific responsibilities and accountabilities.

Provider level governance processes were being reviewed to explore how to best support the service achieve consistent high-quality support. The provider had allocated internal quality support staff to work with staff and management on-site until issues had been resolved. Current staffing structures had been revised and new posts had been created within the local staff team. This would help to ensure there were enough resources to support the registered manager to implement and maintain staff and service performance processes.

At the last inspection, we identified that internal communications and management support processes were not always operating effectively. This increased the risk that relevant data might not be accessed or shared appropriately. This also presented a risk that staff would not receive accurate information in a timely manner so they would know about potential risks to quality and safety or what was expected of them.

The provider was in the process of finalising a new internal technology system. This would allow for more efficient communication and information sharing relating to service performance between the service and wider internal management and support networks. This would also allow for more effective provider level oversight to help make sure that all external information sharing and fulfilment of statutory obligations was completed as expected.

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 12 HSCA RA Regulations 2014 Safe care and treatment Failure to do all that is reasonably practical to mitigate risks and provide safe care and treatment to service users 12 (1) (2) (b) Failure to ensure safe and proper management and use of medicines 12 (1) (2) (g)

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Failure to ensure service users were effectively safeguarded from abuse and improper treatment 13 (1) (2) (3)

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure 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 maintained and service performance was evaluated and improved. 17 (1) (2) (a) (b) (c) (f)

The enforcement action we took:

We imposed conditions on the provider's registration.