Reemy Medicare Ltd

Laurel Mount Nursing Home

Inspection report

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13 December 2021
20 December 2021

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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?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Laurel Mount is a residential care home providing personal and nursing care for up to 34 older people, some of who are living with dementia. At the time of the inspection there were 19 people using the service. Accommodation is provided in single rooms over two floors with lift access. There are communal lounge and dining areas on the ground floor.

People's experience of using this service and what we found
People were not always safe. People were at risk of harm as the provider had not identified, assessed or mitigated risks. This included risks related to people's health and care needs as well as environmental risks, including fire safety.

Government guidance on the prevention and control of infection was not always followed which meant people were put at increased risk. Regular COVID-19 tests were not being carried out on staff or people living in the home. COVID-19 checks on visitors to the home were not carried out in accordance with government guidance. Staff were not wearing PPE correctly.

Staff were not fully checked before starting work in the home. Staff did not receive the induction, training and support they needed for their roles. There were not always enough staff on duty to meet people's needs and there was no system in place to determine safe staffing levels.

People did not receive person-centred care and care records did not fully reflect their needs. Medicines were not managed safely. People's nutritional needs were not met.

People were not always treated with respect by staff or had their privacy and dignity maintained. Although some staff were kind and caring, other staff were task focussed and did not respond appropriately to people's needs. There were no activities taking place and there was little to occupy and interest people.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There was a lack of consistent and effective leadership and an ineffective governance structure which meant the service was not appropriately monitored at manager or provider level.

People were supported to keep in touch with family and friends. People had access to healthcare services. Overall people and relatives were satisfied with the service provided.

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

Rating at last inspection
The last rating for the service under the previous provider was good, published on 12 December 2019.

Why we inspected
The inspection was prompted in part due to whistleblowing concerns relating to the management of the service and care provision. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see all the sections of this full report.

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

We have identified breaches in relation to safe care and treatment, person-centred care, staffing, recruitment, consent, nutrition, privacy and dignity and good governance at this inspection.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Laurel Mount Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

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

Service and service type
Laurel Mount is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The registered manager left the service in October 2021. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. An acting manager was in post when we inspected.

Notice of inspection
This inspection was unannounced. Inspection activity started on 8 December 2021 and finished on 20 December 2021. We visited the service on 8 and 13 December 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority commissioners and safeguarding team.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection-
While on site we spent time with people in the communal areas observing the care and support provided by staff. We spoke with ten people who used the service about their experience of the care provided and three relatives. We spoke with nine members of staff including the nominated individual, the manager and nursing, catering, maintenance and care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included ten people's care records and twelve people's medicine records. We looked at five staff recruitment files. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. During and after the inspection we made referrals to the fire authority and to the local authority safeguarding and commissioning teams. We sent a letter to the nominated individual with a summary of our concerns and asked them how they would address them. We reviewed their response and actions on the second day of our inspection.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
- Risks to people were not assessed and managed safely.
- Risk assessments were not accurate and did not provide adequate guidance for staff. For example, one person's falls assessment scored the risk as high, yet there was no plan in place to mitigate the risks.
- People with limited mobility were not supported by staff to move and transfer safely. We observed two separate incidents where staff used unsafe moving and handling techniques.
- The environment was not always safe or well maintained.
- The central heating system was not working in some parts of the home. One person told us it had been faulty for six weeks. Free standing heaters were provided in some rooms. However, these had not been risk assessed and were very hot to touch presenting a risk of injury to people and staff.
- Fire safety was compromised. Fire doors were wedged open, this is not in line with fire safety regulations. The provider was unable to provide records to show all staff working in the home had received fire training. There were no fire drill records. Personal emergency evacuation plans (PEEPs) were out of date and included people no longer living in the home. The fire risk assessment was completed in 2019 and had not been reviewed or updated. We referred our concerns to the fire authority.
- Cleaning solutions were not stored securely and were accessible to people in bathrooms, toilets and ensuite facilities.
- A safety gate at the top of a flight of stairs was unsecured and there was insufficient lighting in the area. A keypad lock was faulty on a door leading to a flight of stone steps down to the basement. These areas were accessible to people and placed them at risk of harm and injury.
- Accident and incident recording was poor. Some people had sustained injuries, yet there was no evidence to show outcomes and risk assessments and care plans had not been updated accordingly. There was no accident and incident analysis to identify any trends or look at lessons learned.

The lack of robust risk management processes meant people were not protected from harm or injury. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
- Government guidance on the prevention and control of infections was not always followed. Staff were not wearing PPE correctly. We saw staff without masks on, staff wearing masks below their noses and under their mouths, staff lowering masks or taking them off when speaking.
- Government guidance states staff should carry out two lateral flow device (LFD) tests a week and a polymerase chain reaction (PCR) test weekly. People should be offered a PCR test every 28 days. People and

staff were not completing regular COVID-19 tests. This meant risks to vulnerable people were increased because they were at a heightened risk of infection.
● Government guidance states staff should check the vaccine status and LFD test results of visiting professionals to the home. No checks were carried out or recorded. When inspectors arrived on the first day they were not asked for any checks until prompted by the inspector and then not recorded. On the second day the nominated individual asked to see LFD tests but did not record this information.
● The manager told us visitors completed an LFD test before visiting. However, records supplied by the provider showed LFD tests and results were not recorded for all visitors to the home.
● The provider did not have an up to date infection control policy in place. The most recent infection control audit was carried out in November 2019.
● People were not always admitted to the service safely. Two people had been admitted to the service. There was evidence of a negative COVID-19 test for one person prior to admission, however there was no evidence of a pre-admission COVID-19 test for the other person.

People were not protected from the risk of infection as control measures were not implemented consistently. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not managed safely.
● Staff were not following safe practices when administering medicines. We observed staff 'potting up' medicines, that was placing tablets from boxes into pots with bits of paper in with the person's name on. Medicines were left with people unattended.
● Care staff applied some prescribed creams however, there were no records to show staff where to apply the cream, how often or to show the cream had been administered.
● Where people were prescribed 'as required' medicines there was no clear guidance for staff about when the medicine could be given, how often, the maximum dose in 24 hours and the time gap between doses.
● People were not always receiving their medicines as prescribed. Two people were prescribed thickeners to be added to their drinks to reduce the risk of choking. These had not been given. We raised this issue on the first day of inspection and the provider said it had been addressed. However, when we returned on the second day, we continued to find issues in this area.
● Medicines were not kept securely. Medicine storage rooms were left wide open with medicines accessible to people, staff and visitors. Some medicines such as prescribed thickeners and creams were stored openly in bedrooms and communal areas of the home.
● The provider was unable to provide evidence to confirm all staff, who administered medicines, had received up to date medicines training and had their competency assessed.

Systems were either not in place or robust enough to demonstrate medicines were managed safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were not enough staff on duty to meet people's needs and keep them safe.
● Duty rotas were not accurate as we found there were fewer staff on duty than shown on the rota.
For example, on one occasion the rota showed five staff on duty, yet only three staff were present.
● One person had an unwitnessed fall and staff had recorded the person was restless but due to low staffing levels they had been unable to monitor the person properly.
● Staff we spoke with raised concerns about staffing levels and felt there were not enough staff.

● Most people we spoke with felt there were enough staff. However, one person told us, "I'm not sure there's enough staff, I can wait all morning and they don't come 'till nearly lunch time."
● The provider did not use a recognised dependency tool to determine the number of staff required. They said they planned to put one in place.

There were not enough staff deployed at all times to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment processes were not robust as required checks had not been completed before staff started work. We reviewed recruitment files for five staff working in the home. There was no evidence of a disclosure and barring service (DBS) check for three of the staff and no references for four of the staff.

Systems were not in place to ensure staff were recruited safely. This placed people at risk of harm. This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe living at the home and this view was shared by relatives.
● Staff were aware of safeguarding procedures though not all of the staff had received safeguarding training.
● The provider was unable to find any safeguarding records other than safeguarding referrals we had made during this inspection.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience
- Staff did not receive the induction, training and support they required to meet people's needs.
- New staff working in the home had not always received an induction. One staff member's records showed they had received no induction or training since starting in post. Another staff member told us they had not completed any induction or training since they started working in the home some months previously.
- Staff said their training was not kept up to date and this was confirmed by the training records we reviewed. Out of 20 staff training records, only three staff had received any training in 2021 and this was limited to two or three subjects.
- We found some staff had received no moving and handling training since commencing employment and others whose training had not been updated since 2019.
- Staff told us they had not received any supervision since the provider took over the home.

Staff had not received the support, training and supervision necessary for them to carry out their roles. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
- People's nutritional needs were not always met.
- People said they enjoyed the food. However, we found individual choices were limited. No menus were displayed. There was no choice of meal at lunchtime though staff told us people could have sandwiches if they did not like the meal on offer. Meals were plated in the kitchen and everyone received the same small portion served on a side plate. No seconds were offered.
- People who required a pureed diet were not always provided with food of the right consistency. We saw meat had been pureed but vegetables and potatoes remained whole and had not been mashed.
- People's weight and food and fluid intake were not monitored effectively. Where food and fluid charts were in place these were incomplete and showed a poor intake.
- Care plans showed some people were to be weighed weekly, this was not done.
- There was no effective oversight or analysis of weights or food and fluid records to ensure appropriate action was taken.

People's nutritional needs were not always met. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

● The service was not always acting within the legal framework for MCA. People's capacity to consent to their care and treatment was not always assessed.
● We found contradictory information in people's care plans regarding their mental capacity. One person's care records showed a DoLS application had been refused as the person was assessed to have capacity. Yet other sections of the care records stated the person lacked capacity.
● Where people's capacity to make a particular decision was uncertain, capacity assessments and best interest decisions had not been completed.
● Some people living at the home had restrictions in place such as bed rails and sensor mats. There were no consent forms or best interest assessments for these decisions.
● There were no DoLS authorisations in place. The provider told us they were working with the local authority to ensure assessments were carried out and DoLS were put in place where required.

People did not have their care and support needs delivered in line with MCA. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs
● People's needs were not fully assessed before they moved into the home.
● Pre-admission assessments for two recent admissions contained insufficient detail to inform staff of people's needs and the support they required. There were no risk assessments in place for either person and initial care plans contained minimal information. When we asked the manager about one of these people they said, "We know very little about (the person)."
● The building was adapted to meet people's needs and parts of the environment were homely and comfortable. People had direct access from the conservatory to a safe garden with a covered seating area.
● Some areas of the home required redecoration and refurbishment. The environment did not promote independence for people living with dementia. For example, all bedroom doors were the same colour, some had no name or photo to help people find their rooms. Some clocks were not set to the correct time.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff supported people to access the healthcare support they needed.
● People's care records confirmed the involvement of other professionals in providing care such as the GP, district nurses and speech and language therapy (SALT) team.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People were not always treated with kindness and compassion by staff.
- People's experiences varied. People and relatives spoke positively about the staff. One person said, "I like the staff, they look after me." Another person told us the staff were very friendly. Some staff were patient and kind and took time to talk with people and checked they were okay. In contrast we saw other staff lacked warmth and empathy and did not interact with people.
- People were not always involved in decisions about their care.
- People and relatives had not been involved in the care planning process.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was not maintained and staff did not always treat people with respect.
- We observed staff raised their voices and called to people across the lounge asking if they wanted to go to the toilet. This was undignified for people and showed a lack of respect for their privacy.
- We saw staff using the same cloth to wipe different people's mouths and hands after a meal.
- Some people had no slippers or shoes on, just socks. Some people's hair looked unkempt. On the second day of the inspection the hairdresser visited and people said how much they enjoyed having their hair done.
- People were not being offered or receiving regular baths and showers. One person told us, "I haven't had a bath because there's something wrong with the plumbing." Staff told us baths and showers had not been taking place in the last few months due to a lack of staff.

People were not treated by staff with compassion, dignity and respect. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People did not always receive person-centred care.
- People's care records lacked detail and did not reflect people's current needs. Care files were disorganised. Staff said they did not look at people's care records and relied on verbal handover.
- Care plans for people recently admitted to the service contained minimal information about their assessed needs and the support they required from staff.
- Care plans were not being followed by staff. For example, one person's care plan showed they preferred a peaceful and quiet environment to minimise their anxiety. We saw the person was sat in the lounge in a chair closest to the television. The environment was not quiet or peaceful and the person was anxious and unsettled for most of the day.
- People's care records were not reviewed or updated when changes occurred. For example, one person had sustained an injury from spilling a hot drink. Care plans and risk assessment had not been updated following this incident.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Communication care plans were in place although the information provided was minimal.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People's social care needs were not met.
- The provider employed an activity co-ordinator, however this staff member also covered other roles and was working in the kitchen on both days of the inspection.
- There was no activities plan and there were no activities taking place when we visited the service. We saw people spent time in their bedrooms or sat in the communal areas.
- We saw some people enjoyed chatting with staff. Yet we also observed people who had minimal stimulation or interaction from staff.
- People were supported to keep in touch with family and friends. This included pre-arranged internal visits.

People were not receiving person-centred care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● The complaints procedure was displayed in the entrance to the home, however this had not been updated and referred to the previous provider and registered manager.

● The complaints policy was dated 2015 and required updating.

● The manager told us there had been no complaints. The last formal complaint on file was dated 2018.

● People and relatives told us if they had any concerns they would raise these with the staff.

End of life care and support

● End of life care plans were in place for some people. One person's care plans showed the involvement of family in determining the person's wishes and preferences for end of life care.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- Significant and serious shortfalls were identified with the management and oversight of the service during this inspection. There were breaches in relation to safe care and treatment, consent, staffing, recruitment, nutrition, person-centred care and dignity and respect. These issues had not been identified or addressed through the provider's own governance systems.
- On the first day of our inspection we informed the provider of our concerns and requested a response detailing the action they would take to ensure people were safe. The provider sent an action plan which provided assurances. When we returned on the second day, we found issues had not been addressed and identified additional concerns.
- There was a lack of effective management and leadership. The registered manager had been absent from the service since 1 October 2021 and deregistered with CQC on 15 November 2021.
- Staff we spoke with raised concerns about the management of the service. Some said they had raised concerns directly with the providers and management but felt these had not been listened to or acted on.
- The office was disorganised and many of the documents we requested could not be located. The provider told us they had no computer access. They said the computer, which contained information about staff and people who used the service, had reverted to factory settings two weeks prior to the inspection.
- The nominated individual and the director of the company were both living in the home and working shifts as part of the staffing numbers. However, provider oversight and monitoring was ineffective in identifying and managing organisational risk.
- Systems for managing risks to people's health and safety were ineffective. Accident, incident and falls records were missing which meant we could not be assured these had been dealt with appropriately or that people had received the care and support they required.
- There were no robust systems in place to ensure the premises and equipment were well maintained and safe.
- There were no effective quality assurance systems in place. We asked to see all the quality audits carried out since the provider took over the home in March 2021. We were shown a health and safety audit completed in August 2021 and a mattress check completed in July 2021. Both audits were incomplete and it was not clear who had carried out the audit.

● The provider was required to notify CQC about certain events including incidents where a person has or is suspected of having sustained a serious injury. We found these notifications had not been submitted by the provider. This will be dealt with outside the inspection process.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Overall people and relatives were satisfied with the service. However, people and relatives we spoke with did not know who was managing the service and one relative was not aware there had been a change in provider.

● There were limited opportunities for people to be involved and express their views and opinions about the service. People told us there were no residents meetings and this was confirmed by the manager.

● Staff told us there had been no staff meetings. The manager could not find any staff meeting records.

We found systems to assess, monitor and improve the service were not effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● Care records showed the service worked in partnership with health and social care professionals.