Vaghjiani Limited

The Laurels Nursing Home

Inspection report

Lincoln Road
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Lincolnshire
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Tel: 01673858680

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14 September 2021

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Laurels Nursing Home is a residential care home providing personal and nursing care to 18 people aged 65 and over at the time of the inspection. The service can support up to 30 people. The care home is in an old house with a modern single-story extension.

People's experience of using this service and what we found
The provider had failed to ensure that there was adequate management at the home. The registered manager was away from the home for a prolonged period and arrangements put in place to manage the home were inadequate and ineffective.

There was a lack of oversight at the home. Audits had not been completed to monitor the quality and safety of the care provided. When concerns were raised effective action was not taken to keep people safe.

Risks to people were not properly assessed and care was not provided in a manner to reduce risks to people. Medicines were not safely managed and infection control processes in the home did not keep people safe from the risk of infection.

There were not enough staff in the home to meet people's needs in a timely fashion and staff did not have the skills needed to care for people safely.

Staff had failed to report concerns raised to them about possible abuse in the home.

People's rights had not been respected. 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.

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 this service was requires improvement (published 20 August 2020).
We also inspected the home with reports published on 15 January 2021 and 24 February 2021. These were targeted inspections and we did not review entire key questions, therefore we did not review the rating at these inspections.

Why we inspected
We received concerns in relation to people's safety at the home, the management of medicines and the management of the home. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key

questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.
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 the Safe and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end 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 the safeguarding of people from abuse, management of risks, medicines, infection control, staffing and the management of the home at this inspection.

We imposed conditions on the registration of this provider to restrict admissions to the home and drive improvements in care. Furthermore, we took action to close the service under The Health and Social Care Act 2008 and this action was successful.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
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 of the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Laurels 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 team consisted of two inspectors.

Service and service type
The Laurels Nursing home 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

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 and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with six people who used the service about their experience of the care provided. We spoke with two members of staff, the nurse and a care worker. We spent time observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• People were not protected from the risk of abuse. When people raised concerns about their safety in the home, staff did not take appropriate steps to keep them safe. Concerns were not raised appropriately with the local authority and notifications were not submitted to CQC. For example, one person raised concerns that another person living at the home had physically hurt them. This was not raised as a safeguarding.
• Staff did not provide the care people needed and people were at risk of being neglected. For example, one person was sat in the chair in their bedroom, they had a bowl of vomit in front of them. They were in a T-shirt and continence pad with one sock on. There was no sign of their other sock. There was a wet wipe with faeces on it in their bedroom sink. For another person, there was no record of personal care being administered for nine days from 1 September 2021 to 14 September 2021.
• People's rights under the Mental Capacity Act (2005) were not respected and there was no system in place to effectively manage the Deprivation of Liberty Safeguard authorisations in the home. This left people at risk of being detained in the home unlawfully.

People had been placed at risk of harm and neglect. This was a breach of regulation 13 (Safeguarding service users from abuse and improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Risks to people were not properly assessed and care was not always planned to keep people safe. For example, one person who lacked the capacity to keep themselves safe, had been able to leave the home by themselves. Where people were at risk of developing pressure ulcers, staff had not ensured that they had been repositioned in line with their care plan to reduce the risk of ulcers developing.
• Risks were not reviewed when people's needs changed. For example, one person had fallen three times since their admission. In addition, they had developed multiple infections which would impact on their ability to move safely around the home. There was no review of the person's mobility and falls reassessment did not fully take into account their ongoing falls. This failure to assess and mitigate risk placed them at risk of harm.
• People were not supported to eat and drink enough to maintain their well-being. One person's care plan recorded that they were independent with their eating. However, their health had declined and no review of their needs had taken place. There was a bowl of porridge and a drink on their bedside table for 45 minutes going cold. Their food chart for the morning recorded that they had refused their breakfast.
• Care plans did not fully support staff when service users became distressed. One person's care plan showed their behaviours posed a risk to themselves and others. There was a lack of guidance for staff on

how to support the person when they became distressed. Staff were not monitoring their where abouts or their interactions with others, this placed them and others at risk of harm.

Using medicines safely
• Medicines had not been administered to support people's well-being. One person was taking a medicine to manage symptoms of their disease which impacted on their day to day life. It was beneficial to the person to receive their first dose of the day as early as possible to manage their symptoms. Their care plan did not provide guidance for staff on the importance of their medicine being administered promptly. This meant the person experienced more symptoms than they should.
• Medicines were not kept securely. There was a prescribed cream on the floor a person's bedroom. The top to the cream was missing and the cream should have been stored in a refrigerator. The person lacked the capacity to understand the risks of using or ingesting this medicine. This placed them at risk of harm.
• Care plans did not accurately reflect people's needs around their medicines. For example, one person's care plan stated they were compliant with taking medicines. However, a member of staff said the person sometimes refused and would hide medicines in their month and spit them out. This meant there was a risk of them not getting medicines which supported them to manage their dementia.

Preventing and controlling infection
• People were left with dirty bedding and unclean rooms. For example, one person who was cared for in bed, had received their personal care for the morning. Their bedsheets which had been placed over them were soiled with faecal matter. This was on the top of the bedsheet near their hands. The person had been given their breakfast in this position and so there was a risk of cross infection. In another person's bedroom their bedding was soiled, and their floor was dirty. There was a wet wipe soiled with faeces in their sink. The chair they were sat in was stained with urine and when the pressure cushion was lifted it was wet with urine between the seat and the cushion.
• Staff did not support people to maintain a clean environment. In one person's bedroom there was a used continence pad on the floor. A member of staff entered the room to bring the person their lunch, they left the bedroom without attending to the continence pad.
• The staff at the home failed to request evidence of COVID-19 tests before letting visitors enter the home. We could not be sure that people who moved into the home had received tests as set out in the government guidance to keep people living at the home safe. Staff were unable to provide any evidence of what tests had been completed. This placed people and staff at risk of infection.

People in the home had been placed at risk of harm as risks were not fully assessed and care had not been delivered in a way which kept people safe, medicines had not been managed safely and effectively and infection control processes in the home were not effective. 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 with the skills needed to meet people's needs in a timely and effective manner. Two staff had not started their shift at the times indicated on the rota. The amount of staff on shift had not been enough to support people to receive their care in a timely fashion and people were still receiving their personal care at midday.
• Staff neglected people's dignity. People were left in continence products with no other covering on their bottom half. Some of their bedroom doors were open meaning people and visitors could tell if people had used their continence pad One person told us staff did not support them when necessary, they said, "They could change my pad a bit more, I was sat here in my chair and I was wet."
• Staff did not have the skills needed to provide safe effective care. One person told us staff were not always friendly and had an attitude of 'Now what do you want'. The person told us they had been sat in their chair

all day and had to nearly beg to be put to bed. They said, "They (staff) have their own mind and don't listen to me."
• Staff were not deployed effectively to ensure the safety of people living at the home. The handover for each shift could take up to 25 minutes. However, there was no time built into the handover period to ensure the staff from the previous shift were still on shift during the handover period. This meant that there would be a period of 25 minutes where there were no staff on the floor monitoring people's needs or safety.

There were not enough staff and staff did not have the skills needed to support people to have their needs met. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was insufficient leadership at the home. The registered manager was on leave and had been since June 2021. A member of staff had been allocated10 hours supernumerary to manage the service, on other shifts they are deployed as a nurse. The registered manager had been deployed for 40 hours per week for their management duties, this meant there was a reduction of 30 hours a week in management time.
- The member of staff taking over the management role had not managed a care home before and lacked the skills and knowledge to ensure the safe management of the home. The staff became focused on completing tasks and not on providing care centred around people's needs.
- Staff had not been deployed to work effectively in the home so people's needs were met, and staff could be held accountable for their own area of work. The last allocation sheet identifying the people staff had been allocated to support had been completed 10 June 2021. This meant there was no way to identify if staff were not working effectively and needed further support.
- Audits to monitor the quality and safety of the care provided had not been completed for a prolonged period. This meant the provider did not have clear oversight of risks in the home. In response to concerns raised the provider developed an action plan. However, the action plan did not address the serious concerns about people's safety and did not address the concerns about leadership. We received no assurances about action taken to mitigate risks to people in their care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Incidents were not fully recorded in the home. Therefore, we could not be assured the provider had fulfilled their legal responsibilities in being open and honest with people and their representatives about incidents.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The views of people using the service had not been taken into account. People told us they were not happy with the care they received, and some people told us they no longer wished to live at the home.
- The local authority, alongside community nurses had visited the home to identify areas that needed improvement and people's individual needs were met. They raised their concerns with the provider. At our inspection we found the provider had failed to make the improvements needed to keep people safe and ensure that care met their needs.

The provider lacked oversight of the care needed and systems were not in place to monitor the quality and safety of the care provided. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured systems were in place to identify, assess and mitigate risks to people, to manage medicines safely and to prevent the risk of infections spreading.

The enforcement action we took:

We took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured systems were in place to identify, assess and mitigate risks to people, to manage medicines safely and to prevent the risk of infections spreading.

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 Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured people were protected from abuse and that staff would recognise and report abuse.

The enforcement action we took:

We took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured people were protected from abuse and that staff would

recognise and report abuse.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that the systems in the home were effective in assessing monitoring and improving the quality and safety in the home and risks were not mitigated. The provider had not responded effectively when concerns were raised about the care provided to people.

The enforcement action we took:

We took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that the systems in the home were effective in assessing monitoring and improving the quality and safety in the home and risks were not mitigated. The provider had not responded effectively when concerns were raised about the care provided to people.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were not enough competent and skilled staff in the home to ensure people received safe care.

The enforcement action we took:

We took action to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were not enough competent and skilled staff in the home to ensure people received safe care.

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