SHC Rapkyns Group Limited

The Laurels

Inspection report

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

Summary of findings

Overall summary

We carried out a comprehensive inspection of The Laurels on 20, 21 and 24 June 2018. The inspection was unannounced.

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, and both were looked at during this inspection.

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 self-contained plot of private, access-controlled land in a geographically isolated rural setting. The service is separated into four different areas called 'Lodges'; Juniper, Cherry, Birch and Aspen. At the time of the inspection there were 27 people living at The Laurels; nine people in Cherry, five people in Birch, five people in Juniper and eight people in Aspen. People have their own bedrooms and each Lodge has a self-contained 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. However, 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 formal 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. An area manager from the organisation had been assuming the registered manager responsibilities for the service on an interim basis since then.

The service had recruited a manager to permanently fulfil the registered manager's role at the beginning of June 2018. The manager was now 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 commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. Between May 2017 and April 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.

The Laurels was inspected in May 2017 and rated as 'Requires Improvement' overall, including a rating of 'Inadequate' in the Well-led section of the report. We identified multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations, including a breach relating to ineffective quality assurance systems and failure to keep people protected from abuse and improper treatment.

At an inspection in November 2017 the rating for 'Well-led' had improved from 'Inadequate' to 'Requires Improvement'. The service remained rated as overall 'Requires Improvement' and we identified a breach of regulations; The registered person had not ensured that all staff received appropriate training to enable them to carry out the duties. The provider wrote to us to tell us the action they were taking to address this.

We last inspected the service on 21 and 22 February 2018. That inspection was a focused inspection where we only looked at the service performance relating to the key lines of enquiry 'Safe' and 'Well-Led'. The inspection was prompted in response to concerns shared with the CQC by the local authority safeguarding team. The concerns were regarding people who might present physically challenging behaviour receiving unsafe support from staff.

At this last inspection in February 2018, we rated the service as inadequate in 'Safe' and 'Well-Led'. We identified breaches of the regulations regarding failures to keep people safe from abuse and improper treatment, provide safe care and treatment and operate effective quality assurance systems. Therefore, following this inspection the overall rating changed to 'Inadequate' and the service was placed 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. At this inspection we found the provider had not taken effective action to improve the service. The overall rating for this service is 'Inadequate' and 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 take action to prevent the provider from operating this service. This will lead to cancelling or varying the terms of their registration.

Risks and quality issues at the service had not always been identified. Where risks and quality issues had been identified, actions were not always assessed and prioritised effectively to make sure urgent issues could be, and were, achieved in a timely manner. Actions that were implemented were not adequately monitored by management to ensure the quality and safety of the service was continually improving.

The provider had failed to ensure sufficiently skilled and trained staff were deployed to meet people's needs. Staff were not always aware of what they were expected to do or have support to understand their specific responsibilities and accountabilities.

The service was not managing or monitoring risks to people's safety adequately. Staff were not always aware of risks to people. People who displayed behaviours that can challenge were not having their needs met and had been subject to unsafe support, including unnecessary and unsafe forms of control and restraint. Medicines were not being safely or properly managed.

Legal requirements of the service had not always been met. This included submission of CQC statutory notifications and sharing of required information with other agencies related to the service.

Systems and processes to safeguarded people from abuse were not operating effectively. Safeguarding incidents had not been adequately reviewed internally or reported to the local authority to gain input from external health and social care professionals.

Records relating to people's health care and support, including complex nutrition and hydration support, were not being completed consistently and this was not being monitored or managed effectively. We have made a recommendation about seeking advice, implementing and using healthcare monitoring systems effectively.

The service was not always obtaining appropriate consent from people regarding their care and treatment. People's support was not always provided in line with the principles of the Mental Capacity Act 2005 (MCA). Assessments of people's needs were not effective and people's support was not always appropriate, met their needs or fully reflected their preferences.

People's care plans were health focused and included limited information about people's social and emotional needs. People's support was not always person-centred or responsive to allow people to follow their individual interests or achieve their aspirations. People did not have support to access the wider community and take part in meaningful activities.

People's dignity and privacy was not always respected. Staff had not always had the time to get to know people or access information about them. Some staff lacked knowledge about how people preferred to communicate or how to encourage them to express their views.

Historical physical environment issues relating to fire safety and decoration had been addressed. Plans were in place to make further adaptions to areas of the service to better meet people's needs and promote their independence.

People told us there was a lot of support to socialise with other people at the service. Visitors were welcome to the service. People also had support to arrange visits to see and stay in touch with their relatives. This helped people to avoid becoming isolated and maintain relationships with important people in their lives.

People told us staff were kind. We observed staff engaging with people in a compassionate manner.

There had been a very recent change in management and the new manager hoped to implement changes to address the issues to achieve the expected quality of support for people at the service.

Staff told us that the recent change in management had been positive and they were being involved in the attempts to develop the service. People and their relatives also told us that there had recently been a renewed emphasis on encouraging them to share their views on issues and how to make suggestions about how the service could be improved.

In June 2018 we imposed a condition on the providers registration to require them to take action in respect of safe management of medicines.The condition requires the provider to submit a monthly report to the Commission on their actions to improve in this area. We also imposed a condition to restrict admissions to the Laurels.

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 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.

Medicines were not being managed safely.

Risks to people were not being managed safely.

People were not protected from abuse and improper treatment.

Staff were not sufficiently trained or skilled.

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

Is the service effective?

Inadequate

The service was not effective.

Assessments of people's needs were not effective.

Staff did not always work well together within or across services to deliver appropriate support that met people's needs.

People's support was not always delivered in line with the principles of the Mental Capacity Act 2005.

People's eating and drinking and healthcare needs were not always met effectively.

Not all areas of the service had been adapted or designed to meet people's needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity and privacy was not always respected.

Staff had not always had time to get to know people or access information about them.

Some staff lacked knowledge about how people preferred to communicate or how to encourage them to express their views.

We observed staff engaging with people in a compassionate manner.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have regular support to access the wider community.

People's care plans and support were not always person-centred.

People did not always have support to follow their individual interests and take part in meaningful activities.

People had support to stay in touch with important people in their lives.

There was a complaints policy in place and complaints were managed appropriately.

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.

Staff were not always supported to understand their specific responsibilities and accountabilities.

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

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 checked 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 20, 21 and 24 June 2018 and was unannounced.

Over the course of the inspection we visited the service on both weekdays and over the weekend. 20 and 21 June were weekdays and 24 June was at the weekend.

On 20 June the inspection team consisted of three inspectors, a specialist advisor with specialist experience in nursing 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. On 21 June the inspection team consisted of three inspectors and two specialist advisors with specialist experience in nursing and medicines. On 24 June the inspection team consisted of two inspectors.

We used information the provider sent us from the 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 13 staff members, four agency staff, one registered nurse, six agency registered nurses, the chef, the deputy manager, the service manager, the area operations manager, the chief operations officer and the provider's nominated individual.

We 'pathway tracked' 10 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 eight people and five people's relatives. We observed people's support across all areas of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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, staff rotas and information about activities people were supported with and provided by the service.

Inadequate

Is the service safe?

Our findings

People we spoke with did not raise any specific concerns over their safety. One person told us they had been encouraged to raise any concerns they might have about their safety with staff. A person's relative told us they thought that the safety of their relative, other people and of the environment at the service was, "Generally good". However, we found that the service was not safe and several areas of practice were inadequate.

Prior to this inspection the West Sussex County Council (WSCC) Safeguarding Adults team shared information of concern with the Care Quality Commission (CQC) relating to specific allegations of unsafe practice and abuse by staff towards people living in the Aspen Lodge unit of service. These allegations included physical assault and unauthorised restraint of people. WSCC also raised other concerns with the CQC prior to this inspection. These concerns were regarding incidents of physical assault between people, insufficient staffing levels and an unsafe physical environment in people's bedrooms in Aspen Lodge. These concerns all potentially placed people at increased risk of abuse and harm.

We had received similar safeguarding allegations regarding people living at Aspen Lodge from WSCC prior to our last inspection on 21 and 22 February 2018. People living in Aspen Lodge have learning disabilities and some people had a diagnosis of autism. Some people could display associated complex behaviours, including physically challenging other people at the service and staff.

During the last inspection, we identified that systems, processes and practices did not adequately safeguard people from abuse. In Aspen Lodge, there were insufficient numbers of skilled staff to minimise risks to people or themselves when people displayed physically challenging behaviour. This meant people who displayed these behaviours were subject to unnecessary and unsafe control and restraint.

This failure to safeguard people from abuse and improper treatment was a continued breach of regulations. The provider sent us assurances, including an action plan, outlining how they would respond to keep people safe. At this inspection we looked to see if the most recent allegations were substantive and if the provider had acted to address these issues.

The provider had identified, set timeframes for completion and were in the process of implementing actions to provide enough skilled staff to reduce the risks of abuse and unsafe support. However, several actions had not been completed within the stipulated timeframes. Where actions had been, or were in the process of being implemented, they had not been effective. This meant people were not safeguarded from abuse or improper treatment, including unnecessary and unsafe control and restraint.

At the time of this inspection, nine people lived in Aspen Lodge. People living there could present behaviours that challenged, including physically challenging behaviour towards other people and staff. An internal 'Autism Lead' from the organisation had been deployed to work with staff and people in Aspen Lodge to support staff understanding and best practice ways of working for people with autism. This included promoting a Positive Behaviour Support (PBS) approach and writing specific PBS plans for people

with challenging behaviour support needs.

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 towards people who may display or be at risk of displaying challenging behaviour. This enables people to enhance their quality of life and learn new skills to replace the challenging behaviour.

However, we found that at the time of the inspection formal PBS plans were only in place for one person in Aspen Lodge and staff were not confident in how to deliver effective PBS support to people. 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 the least restrictive way.

Other methods of communicating PBS best practice between the Autism Lead and staff were not effective. The Autism Lead told us, "You show staff things one day and then have to show them again the next, staff don't feel they have the autonomy to make decisions. People aren't getting the support they need". The area manager told us work to improve interaction and use of restrictive practice between staff and people in Aspen Lodge was underway but, "Work is still on-going. Staff have issues, there is an ingrained culture and staff are not buying onto the changes. Staff will tell you they understand more than they do".

Where formal PBS plans were in place, staff were not consistent in using the described control measures to help people manage their challenging behaviour safely. During our inspection, we observed that structured PBS tools, engagement techniques, routines and interventions described in PBS plans were not followed by staff when supporting people who required them.

Incident reports described situations where staff had not provided support to people in line with PBS guidelines prior to the person becoming physically challenging. Staff had instead responded to people's behaviours using restrictive practice, including physical, chemical and environmental restraint. This disproportionate response significantly disregarded people's needs and had resulted in people being subjected to unnecessary control and restraint.

People had other risk assessments in place that included information about how to manage their challenging behaviour. For example, people had been identified as requiring medicines to help subdue their behaviours, a practice that is recognised as being a form of chemical restraint. For some people, their risk assessments identified the use of physically restrictive interventions as being a necessary control measure to keep themselves and others safe.

However, people's behaviour risk assessments were not always accurate, up to date or available to relevant staff. Staff supporting people with challenging behaviour who could require physical intervention support had not always received the correct training to be able to do this. This meant staff did not always understand or know how to safely support people.

For example, one person who displayed physically challenging behaviour had five different support plans and risks assessments in place. Each plan contained different advice and guidance for staff about how to safely manage their behaviours, including chemical, environmental and physical restraint. Inconsistencies between plans included different descriptions of which forms of physical restraint should be used and when these should be employed.

We spoke with staff who had read one version of the person's behaviour plans and risk assessments but not

others. Other staff told us they had not yet had any behavioural plans or risk assessments made available to them. Staff told us they were working, or had worked, with people who might need to be supported using physical intervention without receiving the appropriate training. Staff training records confirmed that many staff who were yet to have the correct physical intervention training routinely worked with people in Aspen Lodge who might need this support. This increased the risk of abuse or improper treatment occurring.

For example, incident reports showed that a person had routinely been offered chemical restraint medicines inappropriately by staff responding to them displaying challenging behaviour, where it had not been necessary to do so. Incidents had regularly occurred where people had attacked themselves, staff and other people living in Aspen Lodge. Incidents had resulted in people becoming bruised and their clothes ripped. Staff had had their hair and clothes ripped and obtained grazes. In several incidents, staff had used unauthorised physical restraint techniques in response, or attempted to use authorised techniques they had not been trained for, in response to physically challenging behaviour.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last inspection, we identified that the provider did not have effective systems and processes that safeguarded people from abuse and were not managing or monitoring risks to people's safety. Safeguarding incidents had not been adequately reviewed internally or reported to the local authority to gain input from external health and social care professionals. At this inspection we looked to see if the provider had acted to address these issues.

The provider had implemented new systems and processes to keep people safe from abuse. Staff had received safeguarding training to help them to know how to recognise and report any signs of abuse to help stop or prevent this. A new reporting system had been put in place to allow staff to raise any concerns and record and report incidents and accidents in more detail, including antecedent factors and descriptions of support offered during and after the event.

There was a more comprehensive system of the service management review of safeguarding incidents and accidents, including records of actions taken in response, learning and actions to take moving forward. Processes included in-depth internal reviews with senior managers and quality teams as well as prompts to share details of incidents with external agencies in response to safeguarding incidents. These measures were designed to gain further specialist input in response to incidents and accidents to help meet people's needs.

However, these systems and processes were not effectively implemented. There had been inadequate communication with staff about how to use the recording and reporting systems. Not all staff were confident about their responsibilities to report safeguarding incidents and how to use the system to do this. Safeguarding incidents had occurred where staff had not recorded sufficient detail or made management aware of what had happened. This meant there had been insufficient review and consideration of actions needed to address the issues and prevent them re-occurring.

Where management had been aware of safeguarding incidents, there continued to be an inconsistent response. Some incidents had not been effectively reviewed internally or shared with the local authority for review. This had meant opportunities for any necessary further support and control measures had not been implemented to help the person involved and keep other people and staff as safe as possible.

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 safe and proper use of medicines across all units of the service. Medicines were at increased risk of theft or misuse and people were at risk of not receiving their intended medicines or receiving unsafe or ineffective medicines. At this inspection we looked to see if the provider had acted to address these issues.

The service had implemented a new stock control system to include daily and weekly stock counts of boxed medicines at the service. Medication Administration Records (MARs) were also in place. MARs included information about people and the medicines they needed, including details about how their medicines should be taken or used and how often. People had assessments in place detailing the level of support they needed to take their medicines safely. Medicines were stored safely and securely.

Registered nurses were responsible for administration and management of medicines and had received training to do this. Registered nurses signed MARs and completed stock control sheets after supporting people to take their medicines. These processes were designed to evidence that staff had supported people to receive their intended medicines and keep an accurate total of how much stock remained.

Management at the service had also implemented regular daily, weekly and monthly in-depth checks of MARs and stock control records to check all these were completed accurately. Management then had the responsibility to identify and address any issues related to storage, recording, ordering, disposal and administration of medicines.

However, we found that these systems and processes had failed to make any necessary improvements and were inadequate in ensuring medicines were being managed safely and properly.

Stock control sheets were not in place for all boxed medicines. Medicines were stored in stock cupboards and in medicine trolleys. There were no instructions on stock control sheets as to if they had been completed to include both stock in the cupboards and stock in the trolleys. Levels of stock recorded on stock control sheets did not always correspond with balances found in stock cupboards, medicine trolleys or with MARs. Where stock control sheets were in place and had been completed, many records showed considerable amounts of unaccounted for missing medicines. This meant the service could not account for levels of stock in the service and would not know if medicines had been misused or stolen.

Weekly audits of stock counts were not in place for all people's medicines. Where weekly stock audits had been completed, these were not always dated. This meant counts could not be checked against MARs to see if they corresponded with medicines that had been given. MAR were not always completed properly or accurately. Management audits had failed to identify, investigate and address stock and MAR discrepancies. This meant it was not known if people had received their medicines as intended.

People had received overdoses of prescribed medicines due to staff administration errors and failures to re-order revised prescriptions for people. People had received medicines after the course of their prescription had expired. Management audits had failed to identify and act to prevent these issues. This meant people had received too much medicine for a protracted period, placing them at risk of harm.

Liquid medicines were not always labelled with opening dates. This presented a risk that people could receive ineffective and unsafe medicines. Support workers who had not received medicine training were applying prescribed and medicated topical creams for people and not recording this. Guidance for people's 'as and when' (PRN) medicines lacked detail about when these should be administered. This represented a significant risk that people could not receive their medicines safely or 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 we found people's nutrition and hydration monitoring and support records contained inconsistent guidance and contained unaccounted for gaps. This meant there was a risk that staff would not know how to support people to meet their needs and the provider could not demonstrate they had provided safe care and treatment. At this inspection we looked to see if the provider had acted to address these issues.

We reviewed documents related to managing risks associated with people's nutrition and hydration support needs. At the last inspection we identified that guidance for staff and monitoring records were not sufficiently robust to mitigate the potential risk of harm for people with 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.

There were detailed guidelines in place about how to safely maintain, operate and deliver the correct nutrition, hydration and medicines to people via their PEG. However, monitoring records to show the PEG equipment and entry sites had been maintained and cleaned as directed were not consistently completed. Records to show people had been supported to have the correct amounts of fluids and medicines via their PEG, as per their support guidelines, were incomplete. This meant it was not known if people were having their needs met and this presented a corresponding high risk of harm.

We reviewed records related to management of other high-risk areas of people's support needs and associated monitoring records, including health conditions such as epilepsy and continence support. There was a lack of detailed guidance available for staff about how to safely manage risks to people who had epilepsy, including how to recognise their seizure activity, when it was necessary and how to administer their emergency medicines.

Records monitoring bowel movements of people identified as being at high risk of constipation were illegible, so staff could not know if they required further support. There was a lack of guidance about how and when to administer medicines to reduce this risk. In both instances, this meant staff could not know how to safely support people to meet their needs, leaving them at risk of harm.

The failure to do all that is reasonably practical to mitigate risks 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 the service regularly used agency nurses and support workers. Agency staff did not always have the same level of experience of working with people with learning disabilities with complex needs as permanent staff. The provider had not always managed their staffing rotas to allocate the right mix of permanent and agency staff on shifts to ensure people's needs could be safely met.

At the time of the inspection, the service was heavily under recruited due to consistent staff turnover. We found that the service could ensure that there were enough physical numbers of staff to match people's allocated support needs. However, the service continued to use high numbers of agency staff across all units of The Laurels to backfill the existing vacancies. Although there were sufficient numbers of staff, rotas had not been managed to ensure that there was the right mix of skilled, experienced and knowledgeable staff on each shift to meet people's needs safely.

For example, on 20 and 21 June an agency registered nurse was the designated person responsible for

overseeing the safe provision of care for people living in Juniper, Cherry and Birch Lodge between 08:00 and 20:00. However, despite this level of responsibility on both days the nurses in charge had very little prior knowledge about people at the service or experience of working at The Laurels. For example, On 20 June the agency nurse in charge had worked at The Laurels for three previous shifts. The agency nurse in charge on 21 June was working at The Laurels for the second time.

Both nurses told us they had been given a checklist of health and safety information, such as where fire exits were, on their first shift. Apart from this they had not had any formal induction, been given information about people living at The Laurels or chance to shadow experienced staff before being given charge of the units.

Both nurses told us they had no experience in supporting people with learning disabilities or epilepsy. They told us their primary responsibilities were to administer medicines and manage people's PEG and wound management support. We asked the nurses how they were confident that they could deliver support and supervise staff to be able to safely deliver care to people with such a limited amount of experience and associated skills. The nurses replied they could ask the deputy manager for advice. However, this system was not effective in ensuring staff had appropriate support to carry out their duties effectively.

For example, we raised issues regarding unsafe management and monitoring of PEG management with the deputy manager, they were unaware of this issue and could not tell us how they had or would support staff to carry this out effectively. When showed incomplete PEG monitoring and support records to them, the deputy manager said, "the agency nurses aren't writing that they are doing daily PEG care. I can see that. There is one permanent nurse that does record it, but the agency nurses don't. I think they need reminding".

We visited The Laurels on Sunday 24 June and found that all seven support workers directly providing care to people living in Aspen Lodge were agency workers. Some of the agency workers had worked in Aspen before and had some knowledge of the people living there and how to meet their need. However, some agency staff had not worked in Aspen very often or at all and did not know people. Everyone we spoke with had not read people's care documents, had shadowing opportunities or received physical intervention training.

Agency staff were overseen by a permanent team leader and they told us they could speak with them if they needed advice. However, this system was not effective in ensuring staff were deployed and supported safely to carry out duties assigned to them.

For example, one of the agency workers on 24 June was working at The Laurels for their second shift. They had been allocated to support a person who may become physically challenging. They told us they had no previous experience of supporting someone with these needs, had not had appropriate training and had not read any support information about how to support the person safely.

The agency staff had brought this to the attention of the team leader. The staff member asked the team leader that they not support the person as, along with their lack of suitable skills and knowledge, they had witnessed an incident of the person assaulting staff and being physically restrained the day before. They told the team leader they did not feel safe and they were not confident to support the person. However, as staffing records confirmed, the team leader had allocated the staff member to support the person despite their concerns and the significant risk to people and staff's safety.

The failure to ensure that suitably competent, skilled and experienced staff were deployed to meet people's needs safely is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

At the last inspection concerns were shared with us by WSCC relating to possible unsafe physical environment across areas of the service, including people's bedrooms in Aspen Lodge. The provider was aware of these concerns and had a schedule of works in place to address the issues. WSCC shared similar concerns with us prior to this inspection. We checked to see if the provider had maintained a safe environment for people living in Aspen Lodge.

We found that some areas of the physical environment in Aspen Lodge, including people's bedrooms, required attention but that no issues presented an immediate or high risk to people's safety. We were shown a schedule of works that evidenced the provider was aware of these issues and had planned to address them. Following the inspection, the provider confirmed that further actions had been completed and other maintenance was on course to be finished within the planned timeframes.

Following the last inspection, WSCC Fire and Rescue service issued an enforcement notice to The Laurels for failing to comply with fire safety regulations due to several fire safety risks at the location. The provider was asked to complete a schedule of works to address these issues by 28 June 2018. When we visited we saw work was underway to complete all required actions on the schedule. Following the inspection, WSCC Fire and Rescue service confirmed on 28 June 2018 they had withdrawn the enforcement notice as all items had been satisfactorily completed.

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 effective?

Our findings

Some people told us that the service was supporting them to work towards some of the outcomes they had chosen. People's relatives gave us mixed feedback about how effective the service was. One person's relatives told us, "Their needs are met here". Other relatives told us that people's support was inconsistent and did not always promote a good quality of life for people. We found that the service was not effective and several areas of practice were inadequate.

The Mental Capacity Act (MCA) 2005 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 so that they can receive care and treatment when this is in line with their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the last comprehensive inspection in November 2017, the service was in the process of making improvements to ensure that people's mental capacity assessments were decision specific and staff understood and were providing support in line with the principles of the MCA. The manager at the time of the last inspection was also reviewing people's DoLS to make sure that these had been submitted appropriately. At this inspection we checked to see if these improvements had been made.

Assessments of people's capacity to make certain decisions had been completed. Some people had mental capacity assessments that identified they were unable to make a certain decision and that a relevant person, such as mental health professionals, family members or independent mental capacity advocates, should be consulted to act in their best interests. However, although this had been identified, this was not always done. This meant relevant people had not been consulted with prior to staff making decisions on people's behalf about their support. This increased the risk that people could be subject to support that might not be in their best interests.

Assessments and applications for DoLS had been made on people's behalf. These outlined the specific conditions to deprive a person of their liberty which were being requested. Some applications had been granted and others were pending authorisation. However, it was not always documented that representatives had been consulted when requests for reviews of DoLS conditions had been made or before the conditions had been put into place. This increased the risk that restrictive practices were occurring that were not proportionate or in people's best interests.

Not all staff we spoke with had received MCA and DoLS training. Not all staff could explain the consent and decision-making requirements of the MCA. Some staff had limited knowledge about people's individual capacity and which decisions it might be appropriate to support them to make. This increased the risk that

people may receive support they had not consented to.

The failure to evidence and ensure that people and those acting lawfully on their behalf had given consent before being provided with support is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last comprehensive inspection in November 2017, we identified staff did not always receive appropriate training. This meant the service could not ensure staff were delivering the standard of care they were employed to perform. We found this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in February 2018 we identified that the service remained in breach of Regulation 18. We found that staff were working with people with learning disabilities and autism, some of whom required specialist equipment and support to meet complex needs including epilepsy, challenging behaviour, PEG and suction machines. However, staff were not always suitably trained, skilled or experienced to meet these complex needs safely.

At this inspection we checked to see if the provider had taken action to address these issues. Permanent staff completed an induction and were offered a variety of on-going training courses from the provider's in-house training teams. Agency staff were offered a formal orientation of key physical environment safety features at the service and had completed general recognised mandatory health and social care training courses. Agency staff could also be offered additional training from the provider to help them meet the specific needs of the people living at The Laurels.

However, training records showed most permanent and agency staff working at the service at the time of the inspection had yet to receive training to allow them to safely meet the needs of people in areas including; learning disabilities, autism, epilepsy, challenging behaviour and specialist physical intervention training. Support for permanent staff to keep their professional practice and knowledge updated and in line with best practice such as inductions, regular supervisions and appraisals had not consistently been carried out due to turnover and changes in management structure. Although the service was using high numbers of agency staff, beyond a minimal formal orientation of the key physical environment safety features in the service, they did not receive any on-going formal management supervision or support.

The failure to ensure staff employed by the service had received appropriate support and training is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An assessment of people's needs had been carried out by management and staff. Assessments recognised care and support decisions related to any protected characteristics under the Equality Act 2010, such as religious preferences. Where appropriate, relevant people such as relatives and other health and social care professionals had been involved in this process. The assessment was designed to make sure all relevant information about the support people wanted and needed was identified.

However, this process was not effective. Relatives of people living in other units in the service told us that although they felt their family member's health needs had been thoroughly assessed, there was less consideration on meeting people's preferred social outcomes. The manager told us that the current assessment process was, "More clinical than social in nature" and people's psychological and social needs were not always considered in enough detail. This increased the risk that people would not have the right support to identify and achieve all their preferred outcomes.

For some people, the lack of a holistic assessment process had resulted in support being delivered that was not in line with best practice evidence based guidance.
For example, people living in Aspen Lodge had been assessed as needing support with their challenging behaviour using a training methodology that does not consider the psychological or social aspects of the causes of the behaviour. Instead the methodology relies heavily on teaching reactive physical restraint techniques. Current best practice approaches to supporting people with behaviours that may challenge, such as Positive Behaviour Support (PBS), advocates considering all aspects of a persons' physiological, psychological and social needs. This information is then used to deliver effective support that prevents rather than reacts to challenging behaviour, avoiding the need for physical restraint.

Because people's needs were not being considered holistically or in line with best practice guidance in all areas of their lives, this increased the risks that their overall quality of life would continually suffer. For some people living in Aspen Lodge who were being physically restrained unnecessarily via the use of inappropriate techniques, there was also a corresponding risk that this ineffective care may become unsafe and cause physical or psychological harm.

At the last comprehensive inspection in November 2017, the service was in the progress of implementing 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 this inspection we saw registered general nurses (RGNs) worked on each shift and completed NEWS observations at the beginning and end of each shift. The service had implemented and adapted the NEWS system to include colour coding. This used colours to indicate the level of risk associated with each observation.

For example, people whose blood pressure was recorded as being low would automatically flag up as red, so staff could see this was a high risk. Staff totalled observations to create a score, which was then analysed. The results of this analysis showed if a person's indicators were changing and gave warning of any escalating healthcare support needs.

However, there was no guidance in place to support staff to understand what these parameters meant and recommended actions to consider according to the final scoring. NEWS had not always been completed for everyone at the service and some people's files only showed blank records.

Where NEWS observations had been recorded, these had not been scored. This meant staff could not effectively assess what had been recorded to see if escalation for further healthcare support was necessary. This increased the 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.

In addition to the above issues regarding ineffective use of NEWS, there had been no consideration of establishing individual baselines of people's normal health indicators, outside of the generic parameters recommended on the NEWS. This is recognised as good practice as people's individual baselines may vary according to their personal health conditions. This further increased the risk that warning signs may not be identified effectively.

We have identified this as area of practice requiring improvement. We recommend that the service seeks support and training from a reputable source and acts to ensure NEWS systems are implemented and

utilised effectively.

Although not always recorded, people and their relatives told us they were regularly involved in discussions about people's wellbeing. This helped to ensure people could access and receive further on-going health support if necessary. Alongside registered nurses, there were internal physiotherapists on-site and GPs and other health professionals regularly visited the service. Staff and relatives also supported people to external healthcare appointments and referrals.

However, some relatives told us that the sharing of information about people's health and treatment options between themselves, the service and other healthcare services was not always effective. They gave an example of how the internal physiotherapist team had misunderstood referral instructions about how to fit postural support equipment for a person. This had resulted in the person suffering a minor skin tear injury and the equipment being ineffective for a protracted period until the mistake was noticed and rectified.

People did not have a single clearly identifiable document which contained important information about their health, social and communication needs that could be referenced in the service, or taken with them to healthcare appointments. This increased the risk that people's healthcare needs may not be understood and they could receive ineffective support or treatment.

The failure to ensure that assessments of people's needs and subsequent support was appropriate, met their needs and reflected their preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The premises of the service had been designed to accommodate people with physical disability support needs. There were wide doorways and corridors to allow for wheelchair access throughout all areas of the service. Equipment such as ceiling track hoists had been installed in individual bathrooms and bedrooms to support people with transferring from one surface to another. The service had an on-site was a sensory room, spa, computer room and gym which people could use whenever they wanted. There was appropriate signage on doors to toilets and other communal rooms and facilities, to help people find their way around the building.

The service had large communal areas in all units where people could take part in activities and meet with other people and visitors. People had access to extensive and well-maintained gardens. People's bedrooms in most units at the service had been personalised with their own pictures, furniture and belongings. Communal areas of the service also contained photographs of people and pictures and posters they had chosen. People had decided on a recent decoration colour scheme and the television had been moved in the lounge following their suggestion this was done.

Not all areas of the service had been adapted or designed to be able to meet people's needs in the most effective way or promote their independence. For example, in Aspen Lodge there was a lack of personalisation in the communal areas. It was not evidenced how people had been involved in making decisions regarding the choices of decorations that were in place. There was a lack of furnishings to allow people to spend time comfortably in communal areas if they wished. Sensory fixtures in the Aspen Lodge communal lounge were generic and not adapted to be able to meet the individual needs of people effectively. Communal kitchen facilities were small, lacking in equipment and were not being used to help support people learn new skills.

The autism lead was aware of the environmental issues in Aspen Lodge requiring significant improvement. There were further plans in place to adapt parts of the premises to better meet people's individual needs

and promote their independence. For example, a new much larger kitchen area with adequate equipment had been designed and was planned to be built shortly. New sensory equipment and more appropriate decoration to communal areas was also underway or planned. These environmental changes would help improve people's quality of life, meet their social and intellectual needs and promote their independence.

People told us they had enough to eat, there was enough choice and the quality of the food was good. One person said, "I enjoy my meals. I have my favourite meals and they come on the menu often enough". We observed that meals were appropriately spaced throughout the day. Meals appeared social occasions that people enjoyed.

People had nutrition care plans that detailed any specific eating and drinking needs. We spoke with the chef, who confirmed this information was shared with them so they were aware of this and they accommodated any specialist dietary needs. For example, preparing pureed or soft food meals for people who required this. People had been referred to dieticians for nutrition advice and the area manager told us that the service planned to introduce more resources to promote awareness of healthy eating for people.

We have reported on the management of risks relating to some people's complex nutrition and hydration needs in the 'Safe' domain of this report.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us that staff were caring. Relatives gave us mixed feedback about the service. Relatives agreed that although permanent staff were kind, unfamiliar agency staff did not always recognise when people needed and wanted support. We found that the service was not always caring and some areas of practice required improvement.

Peoples' relatives told us there were too many agency staff working at the service, who did not always involve people in their support or recognise their needs. One relative said, "Their most familiar carer has been working on another unit for three weeks and during that time it hasn't been so good. They've had poor positioning, lack of mouth care…Regular staff know [name] very well as a person. For a time, they were regularly supported by two agency staff and standards were lower…it's the caring that dipped".

Other relatives had similar concerns over high use of agency staff meaning people's needs were not recognised and they were not involved in decisions about their support. They gave an example of their relatives' support preferences regarding drinking had not always been respected. They said, "two staff here know [name] very well and they can help speak up for them about what they want, but I would be very worried if they had gone as well".

The manager and area manager were aware of the potential risk that high use of agency staff might mean that people did not receive consistent, inclusive and compassionate support. Where possible, familiar agency staff were booked and re-booked in advance to ensure continuity for people and staff to mitigate this risk.

However, we spoke with agency staff who had not always had the time to get to know people or access information about them when working with them. Although agency staff understood the importance of treating people with kindness and compassion, they often lacked the knowledge about how people preferred to communicate or how to encourage them to express their views. This increased the risk people would not be included and their decisions about their support might not always be respected.

For example, agency staff told us they often relied on other staff to share knowledge about people on their behalf. Due to there often being high numbers of agency staff working on the same shift, this made them feel that they were not always confident they could gain accurate information to be able to support people in an inclusive and personal way. One staff said, "Give people choice but you have to just decide based on what you are saying. It's up to you, they can't talk to you, you have to do whatever you think is good".

The failure to enable and support people to understand their care and treatment choices and to enable them to make or participate in making decisions relating to their care is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service had introduced processes and ways of working to help ensure people's privacy and dignity was respected. People's preferences for receiving personal care support from staff of a specific gender was

upheld. We observed signs asking people to knock on people's doors before entering. One person told us that staff did not come into their room without asking.

However, some staff showed a lack of understanding about people's privacy and dignity needs. For example, we observed two agency staff leaving a bathroom door open and both standing and watching the person while they used the toilet, before it was necessary for them to begin supporting them.

The failure to prevent a person from being in an undignified situation whilst receiving personal care is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service had a data protection policy in place that described the provider's commitment to ensuring people's confidentiality was respected. However, this policy had not been updated to include information about how the service was complying with the principles of the recently introduced General Data Protection Regulations (GDPR). This is an area of practice that requires improvement.

We observed people being supported by permanent staff in a kind and compassionate way. For example, while staff were assisting a person's morning personal care routine they were maintaining conversation and constantly checking the person was comfortable, giving explanations and using clearly familiar processes and words. This helped the person feel they mattered and be reassured they were receiving the support they wanted.

Staff understood and could explain the importance of promoting independence and offering people choices and respecting their decisions. One staff member said, "One service user rings their buzzer when they want to get up or tells you they want to be up. They decide what they want to do, they choose their clothes". We saw that for one person who liked to vary their activities frequently, they could make their own choices about where to go at any time. The person required constant supervision for their safety. While staff stayed with them at all times, they did so at varied distances to respect their personal space and autonomy.

We observed staff using ways to communicate with people in ways they could understand. This helped to make sure people felt listened to and could express themselves. For example, we saw a person frequently initiating touching interaction with staff, who acknowledged and responded appropriately.

Requires Improvement

Is the service responsive?

Our findings

People told us they had support to follow some of their interests, including culturally relevant activities. People's relatives gave us mixed feedback about how the service met people's needs in a personalised way. We found the service was not always responsive and several areas of practice required improvement.

People, their relatives and social care professionals, contributed to the planning of people's care. Information about people's strengths and levels of independence were shared with staff and then assessed. Initial information about people's support preferences and needs from these assessments were then recorded in a care plan. This helped make sure staff would know how to support people in a personalised manner and give them the best possible quality of life.

Care plans were in place for people at the service and included some personal information alongside people's support needs. This included broad information about how people's background and history reflected any protected characteristics under the Equality Act 2010 and how this informed any communication, cultural or social needs. Plans described how to meet people's communication needs when sharing information about their support in line with the principles of the Accessible Information Standards (AIS). This helped ensure people's choices would be respected as much as possible.

However, the initial assessment process did not include a balance of detailed information about people's physical, mental, emotional and social needs. This resulted in the creation of care plans that included limited detail about people's individual likes and dislikes, interests and wider social and civil aspirations. Staff understanding of people's needs and wishes in all areas of their life was therefore limited and not always considered fully when planning people's care. This increased the provision of generic and less personalised support.

People told us that staff asked them about their support. Relatives told us that they usually attended an annual review but, if requested, reviews could be arranged more frequently. Health and social care professionals also contributed to an annual review of people's support needs. Staff told us that they discussed people's care with them regularly, although formal monthly reviews of individual's needs were led by staff and did not always involve people directly.

However, while records showed reviews had resulted in changes being made in response to people's healthcare needs, there was a lack of evidence to show people's wider social needs had been considered during the process. This increased the risk that people's support would not be able to effectively build on their strengths and levels of independence and enhance their wider quality of life.

For example, one person had been allocated funding to access further education opportunities. Their relatives explained that although they felt that general day to day support was "pretty good", care planning and reviews had failed to support their family member to take advantage of this opportunity. They said, "We would like to see more from their educational budget. We have a feeling it's not being used. We would like them to go to Crawley College. They only have an educational window for a few more years and we think

they are quite bright".

Staff offered daily activities to people. People could have support to use the on-site facilities such as the gym and IT room or go for walks around the grounds of the service, either on their own or with other people. There was a daily activity schedule of two morning and afternoon group sessions that were delivered in the service on weekdays. The activities co-ordinator told us there were monthly meetings with people and staff to ask for their input on providing internal activities.

However, people and relatives told us group activity schedules did not always consider or reflect people's personal interests or were necessarily appropriate for people's level of support needs. One person said, "I don't like group activities so I don't do them". Relatives told us that the group activities offered were often appeared not to be relevant or meaningful to people. One relative said, "Afternoon activities tend to be crafts undertaken by staff with little service user involvement, although they would be present. It is unusual in my experience to see people being directly involved".

We observed that people's response and involvement with group activities during our inspection was mixed, some people clearly enjoyed them but others did not. For these people, there was not always an alternative offered meaning they remained disinterested and disengaged until the activity had finished.

The failure to design care and treatment with a view to achieving people's preferences and ensuring their needs were met is a breach Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We discussed this with the management and autism lead. The autism lead told us, "Activities are not person-centred, we are in the process of trying to resolve this". The area manager and manager were aware of the lack people's personal information and aspirations in current care plan documents and the impact this had on providing well balanced personalised support for people. The organisation was developing a new person-centred support plan format that would focus on a more holistic care planning process. This would help to identify meaningful individual activities and outcomes and give people more choice and control over their support.

At the last comprehensive inspection in November 2017 we identified that people were receiving very little support to access the wider community to participate in chosen social and cultural activities. This increased the risk of people not being able to follow their individual interests or achieve their aspirations. Due to this, we recommended that the registered person review the opportunities for people to be able to access the wider community. At this inspection, we checked to see if this recommendation had been put into practice.

The activities co-ordinator told us that alongside the activity schedule that was delivered in-house, trips to the community were also arranged for people individually and as group sessions. The service had three vehicles and employed two full time equivalent drivers. Due to the isolated geographical location of the service, these resources were primarily relied on to help people access the wider community. Transport for all people was limited to these resources and had to be booked in advance, which was a barrier for people going out as regularly as they might like.

Specific driving staff were required as a commercial transport driving license was required to drive the service vehicles. Drivers regularly finished early in the day and as two were part-time, this further limited the availability of transport. The service was in the process of purchasing a new vehicle that support staff could drive on a regular licence. This would help people to be able to go out more frequently.

One person said that they had regular support to attend a local church. However, most people's activity

plans that we sampled showed people had not routinely been supported to access the community to follow their interests since the last inspection. The manager said, "The service needs to be more out-going. It is so secluded and the location is all encompassing, everything people do is here". Relatives confirmed that this was a concern to them. One relative said although people did leave the service, it was mostly for group trips and, "They do not go out as frequently as they would like".

Trips out into the community were mainly focused on group recreational activities with other people and staff from the service. People had not been supported to regularly participate in social activities or events involving peers or people from the wider community with similar interests. People had also not been supported to explore employment and education opportunities or participate in other civil and political activities.

The failure to design care or treatment with a view to achieving people's preferences and meeting their needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People told us there was a lot of support to socialise with other people at the service. If people chose to spend time on their own in their rooms, they told us staff would come to see them so they were not alone for long periods. Visitors were welcome to the service. Several people had moved to the service from other parts of the country. The service accommodated people's visitors who had travelled long distances to see them for overnight stays. People also had support to arrange visits to see and stay in touch with their relatives. This helped people to avoid becoming isolated and maintain relationships with important people in their lives.

The manager shared plans of improving links with local communities, including areas where people had come from. They had planned an open day to invite important people in people's lives to visit them at the service and said, "We need to begin inviting more people in".

There was a complaints policy and information about raising concerns was on display in the service entrance. A relative gave us an example of where they had complained about an issue in the past and had been satisfied with the response and outcome. The area manager told us they treated complaints very seriously and looked to resolve all complaints to everyone's satisfaction

The service did not currently support anyone receiving end of life care. People, or relevant people acting on their behalf, had been consulted about how they might wish to approach being supported with their end of life care regarding emergency resuscitation in the event of a medical emergency. If necessary, people could have support with planning, managing and making other decisions about their end of life care. This included ensuring equipment and resources were provided and religious and spiritual wishes were adhered to.

Inadequate

Is the service well-led?

Our findings

Relatives of people told us frequent changes to the management were a concern and this was affecting staff culture and morale negatively. We found the service was not well-led and several areas of practice were inadequate.

At the last comprehensive inspection in November 2017, the service had been rated 'Requires Improvement' in well-led and we identified a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 relating to poor governance and quality assurance systems.

At a focused inspection in February 2018, we identified a continuation of the breach of regulation 17 and the service was rated inadequate in the Well-Led section. We found the service's quality assurance systems had failed to identify risks to people's safety, where provision of care was inappropriate and where people's records had not been maintained. Because of this, the provider had not acted to address these issues. Where risks had been identified, the provider had also failed to act. This left people at significant risk of harm. At this inspection we looked to see if the provider had acted to address these issues.

There had been several changes to quality assurance and governance systems at the service since the last inspection. Daily weekly and monthly reviews of information from safety and quality records were audited by the manager and staff at the service. Reports of audits were created and shared with other internal staff and management, who also carried out their own independent audits.

Although there was no centralised on-going development plan for the service, there were several separate improvement plans that had been created from these audits. Actions were added to the plans, with set timeframes for completion, to address issues and improve quality. Progress of these actions were then overseen at local, middle and senior management level.

Despite these changes, quality assurance systems and governance frameworks remained inadequate. Risks or issues at the service had not always been identified. Where they had been identified, actions were not always assessed and prioritised effectively to make sure urgent issues could be, and were, achieved in a timely manner. Actions that were implemented were not adequately monitored by management to ensure the quality and safety of the service was continually improving.

For example, risks and issues with inappropriate care identified at the last inspection included; medicine management and practice, ineffective systems and process to safeguard people from abuse, use of unnecessary and inappropriate restrictive practice towards people, deployment of insufficient skilled and trained staff and poor maintenance of people's care records. These issues remained outstanding and practice in these areas remained inadequate. This meant people's safety had remained significantly at risk.

Other quality issues identified during the last comprehensive inspection in November 2017 included; lack of consent, person-centred care and support for people to access the community. At the time of this inspection, these issues had not been resolved. Where actions had been identified to improve, these had not

been implemented and monitored effectively or in a timely manner. This had meant quality in these areas of practice had deteriorated. This was having a negative impact on people's quality of life.

At this inspection we also found that sharing of information and advice to help the service to provide good quality support to people with partnership agencies had not always been carried out in a timely and open manner. Suggestions for improving people's care had not always been communicated or followed up with staff effectively. As a result, the service had not implemented the actions as suggested, which affected people's safety and quality of life.

Internal communications and management support processes were not always operating effectively. Staff said, "Communication coming down was not good, things were kept in the dark". The area manager and manager confirmed that information sharing between staff and management and with the wider organisation was poor.

For example, internal information technology systems were not centrally linked so accessing or sharing documents such as service development plans or staffing records was not possible unless using the computer on which they had been originally saved or by sending continual emails of updated documents back and forth between different members of staff.

The service computer system was not internally linked via a network or email system. Management and other staff relied on physically walking to different areas of the service to share and access information via reading or writing hard copies of documents or speaking with staff verbally. 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 area manager and the manager were unable to explain the formal values of the provider but explained they would expect staff to approach their jobs in a way that, "Promotes people we support to achieve their potential through dignity, respect and personalised care". However, formal support processes for all staff had not been occurring consistently. This meant that staff were not always aware of their specific responsibilities and accountabilities and how the expected values should always be displayed when carrying out their roles.

Relatives told us that they had observed this issue had directly affected the delivery of high quality support. One relative said, "The nurses take advantage, every time there is a change of management they slip back, don't do anything unless they are pushed. Nursing staff give the impression any concerns raised are trivial as far as they are concerned, or someone else's problem".

The above failures to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, provision of people's care was appropriate, records related to the provision of support 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.

Due to a change in management since the last inspection in February 2018, there was not currently a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission (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.

An area manager had been appointed and had been fulfilling the role and responsibilities of the registered manager until three weeks before this inspection, when a manager had been recruited to the registered manager's role. The manager had just completed their induction training and was being supported by the area manager for a further period while they were completing the formal registered manager application process.

However, during the period that the service had not had a formally registered manager in post all legal requirements of the service had not been met as expected. This included submission of CQC statutory notifications and sharing of required information with other agencies related to the service.

For example, a notification to CQC following receipt of an allegation regarding physical abuse of a person using the service had not been made as required by law. This information had also not been shared with other agencies related to the service, such as the local authority safeguarding team. Notifications had also not been submitted as required by law regarding potential and actual neglect following incidents where people had not received their medicines as intended due to staff error.

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

The manager and area manager were keen to address quality, morale and motivation issues. They acknowledged that staff culture needed to change to improve the service. They had identified divisions and a lack of co-operation between permanent and agency staff was affecting the delivery of high quality support. They told us they were promoting better communication methods and a more open and inclusive approach with staff between staff and management.

The manager hoped to improve the culture of the service by introducing new values and expected ways of working. They aimed to provide more consistent on-going support for staff to understand their roles, including emphasising the importance of working as one team towards a common goal to achieve the expected quality of support.

Staff told us that despite many issues remaining, the recent change in management had shown signs of being a positive change. One staff member said, "The communication coming down has improved. Staff meetings and team meetings are taking place. The manager and area manager attend the meetings. They have an open-door policy. I feel the atmosphere has changed, it feels more comfortable. They will actually listen and they try to come up with a plan. You feel that your feedback is listened to".

People and their relatives also told us that following the change in management, there was a renewed emphasis on encouraging people to be share their views on issues and how the service could be improved. People said they had recently had meetings to ask for their ideas about how to make the support better. Relatives said they had been sent surveys in the past asking about the quality of the service and had recently been invited to a meeting to discuss current issues and look at how these could be improved. The area manager told us that they planned send out more frequent quality surveys to people and relatives to gain more frequent feedback about how they could develop the service further.

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 9 HSCA RA Regulations 2014 Person-centred care Failure to ensure that assessments of people's needs and subsequent support was appropriate, met their needs and reflected their preferences. Failure to enable and support people to understand their care and treatment choices and to enable them to make or participate in making decisions relating to their care. is a breach of Regulation 9 (1-3) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 10 HSCA RA Regulations 2014 Dignity and respect The failure to prevent a person from being in an undignified situation whilst receiving personal care is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 11 HSCA RA Regulations 2014 Need for consent Failure to evidence and ensure that people and those acting lawfully on their behalf had given consent before being provided with support is a breach of Regulation 11 (1-2) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 12 HSCA RA Regulations 2014 Safe care and treatment Failure to do all that is reasonably practical to mitigate risks to service users, manage medicines safely and ensure that suitably competent, skilled and experienced staff were deployed to meet people's needs safely is a continued breach of Regulation 12 (1-2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the providers registration to require them to take action in respect of safe management of medicines.

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 a

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 is a continued breach of Regulation 13 (1-7) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:

We imposed a condition on the providers registration to restrict admissions to The Laurels.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failures to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, provision of people's care was appropriate, records related to the provision of support were maintained and service performance was evaluated and improved is a continued breach of regulation 17 (1-2) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 18 HSCA RA Regulations 2014 Staffing Failure to ensure staff employed by the service had received appropriate support and training is a continued breach of is a continued breach of Regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed conditions on the provider's registration.