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 well-led?	**Inadequate**

Summary of findings

Overall summary

We undertook an unannounced focused inspection of The Laurels on 10 October 2018.

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

The inspection was prompted in part by notification of an incident following which a person using the service became critically unwell. This incident is subject to a separate investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of choking, aspiration and on-going healthcare support needs for people using the service. This inspection examined those risks. We also looked to see how the service was providing enough skilled staff, preventing and learning from safety incidents, safeguarding people and operating effective quality assurance and governance systems.

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

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

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

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

The Laurels had been built and registered before Registering the Right Support (RRS) had been published. The provider had not developed the service in response to the values that underpin RRS or changes in best practice guidance for providers of learning disability and autism services. These values and guidance includes advocating choice and promotion of independence and inclusion, so people using learning disability or autism services can live as ordinary a life as any other citizen. We found The Laurels did not

always conform to this guidance and values when supporting people or in the model, scale and geographic setting of the service. Due to this, it is unlikely that a request to register The Laurels today would be granted.

The Laurels has been without a registered manager since 10 April 2018. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had recruited a manager to permanently fulfil the registered manager's role at the beginning of June 2018. The manager was in post and in the process of formally registering with the Care Quality Commission (CQC).

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

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

We last inspected the Laurels on 15 and 21 August 2018. This was a focused inspection looking at the key questions 'Safe' and 'Well-Led'. The inspection was prompted by concerns that people using the service may be at risk of harm. Following the August 2018 inspection, the key questions were both rated 'Inadequate' and the overall rating for the service was 'Inadequate'.

This was the third time the service was assessed as 'Inadequate' following receipt of this rating after inspections in February and June 2018. Therefore, the Laurels remained in 'Special Measures'. Services in special measures are kept under review and inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

At this inspection, we focused on specific concerns and looked at the management of risk of choking, aspiration, wound management and on-going healthcare support needs for people using the service. We also looked to see if the provider had made improvements to prevent and learn from safety incidents, safeguard people and operate effective quality assurance and governance systems.

Not all staff had read or had access to people's eating and drinking choking and aspiration risk management assessments and guidelines. Not all of these documents had been recently reviewed. Some people had several different sets of aspirations and choking risk management documents available for staff. In some cases, these documents contained conflicting or incorrect directions.

Where there were directions to take actions if there was a choking incident, people's plans did not always contain enough detail about how to do this safely. Staff had not always had the correct training to be able to take these necessary actions and did not feel confident to do so. Monitoring records of people's eating and drinking to help manage the risks of choking and aspiration were not completed accurately.

There had been incidents at the service where people had been placed at risk of harm when people had not been supported to manage choking and aspiration risks safely by staff. There remained an increased the risk of people coming to harm or that they could be supported inappropriately in ways that did not respect their freedom, choice and control.

Not all staff understood their responsibilities to report accident, incidents or safeguarding concerns internally as soon as possible. Where incidents and safeguarding concerns had been reported internally without an undue delay, information about safeguarding concerns and incidents and accidents was not always shared with partnership agencies by management. Where this had been shared, this had not always been done in a timely manner. This meant further review and investigation to agree all necessary actions keep people as safe as possible did not always happen quickly, or at all.

Systems in use at the service to monitor people's health needs had recently been revised to help identify any potential or actual concerns to people's well-being. Changes had been introduced very recently and were not yet fully embedded. Not all staff working at the service had received support to understand and use the systems. Some staff were not confident about how to use them. This presented a risk that people's health needs might not be monitored effectively and action taken quickly to keep people safe.

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

The provider had not always ensured the service worked effectively with partnership agencies. Feedback from local authority and healthcare professionals raised reservations that management and staff at the service had not always worked in an open and transparent way when being approached to review people's care. The provider was not always ensuring the service was meeting its legal requirements, including submitting statutory notifications of incidents.

The provider had systems in place to ensure that any vacancies were covered by agency staff. On on-going service review was taking place to re-assess people's support levels to make sure they were getting the correct amount of support they were funded for. This had resulted in an initial reduction of overall staffing levels at the service. Staff raised concerns with us about the reduction in staffing levels leaving some people at risk of not meeting their needs. We did not find any people at direct risk of harm from the changes and the provider had restored staffing levels in response to the concerns while the review was on-going.

People said they liked living at the Laurels. There had been several recent changes to the service and higher organisation's management. The current manager was committed to overcoming issues to be able to deliver a good quality service. Staff said management was visible and supportive. People's relatives said although there had been past issues with the management of the service, recent changes made them feel more confident the organisation was committed to improving any issues.

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.

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the

quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

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

This service will be kept under review and, if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will act to prevent the provider from operating this service. This will lead to cancelling or varying the terms of their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people were not being managed safely.

People were not always protected from abuse and unsafe treatment.

Safeguarding concerns were not always reported internally or externally for investigation and to agree appropriate actions to keep people safe.

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

Is the service well-led?

Inadequate

The service was not well-led.

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

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

Statutory notifications had not always been submitted as required.

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

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.

The inspection was prompted in part by notification of an incident following which a person using the service became critically unwell. This incident is subject to a separate investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about management of risk of choking, aspiration and on-going healthcare support needs for people using the service. This inspection examined those risks. We also looked to see how the service was providing enough skilled staff, preventing and learning from safety incidents, safeguarding people and operating effective quality assurance and governance systems.

This inspection took place on 10 October 2018 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor with specialist experience in nursing.

For this inspection we did not request a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This is because we undertook this inspection at short notice due to concerns that we had received from the local authority.

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 three support workers, three agency support workers, one registered

nurse, two agency registered nurses, one team leader, the organisations' quality lead, the organisation's autism specialist, the chef and the service manager. We spoke with three people's relatives and two people. We observed people's support across all areas of the service.

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

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

Inadequate

Is the service safe?

Our findings

People we spoke with did not comment directly on the safety of the service they received. We received mixed feedback from relatives of people using the service. One relative told us they were confident their family member felt, "Safe and secure" living at The Laurels. Another relative told us they did not think staff were always delivering safe care and support for their loved one.

This inspection was prompted by a notification relating to a person using the service becoming critically unwell. This raised concerns about the management of risk of choking, aspiration and on-going healthcare support needs for people using the service.

At the last inspection of the service in August 2018 we found concerns relating to unsafe care and risk management of people's on-going health needs. We also found the provider was not preventing and learning from safety incidents or safeguarding people effectively and there were issues with providing sufficient numbers of suitable staff. The provider continued to be in breach of Regulation 12 and 13 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014.

At this inspection we looked at the concerns that had prompted this inspection. We also looked to see if the provider had made necessary improvements since the last inspection regarding unsafe care and risk management of people's on-going healthcare needs, preventing and learning from safety incidents, safeguarding people and providing enough skilled staff.

We reviewed the management of choking and aspiration risks for people with more complex eating and drinking needs. People had been assessed to identify the support they needed to manage these risks safely. For some people, assessments had been carried out by staff and registered nurses at the service. Other people had been referred for assessment by specialist Speech and Language Therapy (SaLT) professionals.

SaLT or staff had then written risk assessments, care plans and guidelines that detailed the most appropriate way to support people to manage the risks of aspiration or choking. This included the provision of specially designed cutlery, plates and cups, identifying suitable and unsuitable foods, having food mashed or pureed and adding thickeners to drinks. For some people, there were directions for staff to take in the event of a choking incident to keep people safe, such as performing abdominal thrusting techniques, or using a suction machine.

Not all people's eating and drinking choking and aspiration risk management assessments and guidelines had been recently reviewed. Some people had several different risk assessments and care plans available for staff, including documents written both internally and by SaLT. These documents did not always have the same amount of detail as each other and in some cases contained conflicting directions or incorrect information. This increased the risk that assessments and care plans may not contain the best expert professional guidance or have relevant and up to date information so staff would know how to keep people safe from choking or aspirating when eating and drinking.

Where there were directions to take actions if there was a choking incident, plans did not always contain enough detail about how to do this as safely. For example, some people who could not walk independently had been identified as requiring abdominal thrusting if choking. They used large specially designed wheelchairs and spent most of their day in these. There was no information about how staff should consider the people's individual disability when performing the thrust, including how they could safely move the person from their wheelchair or how to deliver the thrusts while the person was sitting down.

Staff had not had specific training and were not confident about how to employ some of the directions in people's eating and drinking risk assessments and care plans. This increased the risk that people may not receive support they needed to stay safe. One staff said, "I haven't done first aid training here. I've been here since 2015. I really don't know what I would do if someone needed abdominal thrusts…We need to talk about this as a team…we need specific training for each individual". An agency staff member said, "I have not had suctioning training or abdominal thrust training, I was told to pat people's back."

Not all agency staff had been given the opportunity to read people's eating and drinking guidelines and risk assessments before supporting them. Where this was the case, agency staff were reliant on permanent staff to be available to offer them directions about how to manage people's risks of choking and aspiration. This meant there was a risk that if permanent staff were not available, agency staff would not know how to support people safely. This increased the risk of people coming to harm or that they could be supported inappropriately in ways that did not respect their freedom, choice and control.

For example, a person was coughing when being given a drink by an agency staff member. When asked if the person required their drink to be thickened, the agency staff member replied, "I don't know" and continued to give the drink. The person had guidelines from SaLT about how to position them safely in their wheelchair that directed staff to refer to their eating and drinking guidelines. The person had no eating and drinking guidelines available to staff, although their MAR did not show they had been prescribed any thickener. On another occasion, an agency staff member attempted to give a person a drink from an inappropriate cup but a passing staff member saw and intervened. If used to drink from, this cup would have increased the likelihood of aspiration occurring for the person.

Other support staff who worked with people at the service alongside support workers, included activity co-ordinators. Activity co-ordinators may be required to support people with eating and drinking on occasion. However, these staff had not always had the opportunity to read people's eating and drinking guidelines or be made aware from permanent staff of how to support people safely with eating and drinking. This also presented an increased risk that people might not get the support they needed and wanted safely or appropriately. For example, there had been a recent incident where an activity support staff have given a person an inappropriate piece of cutlery to eat, rather than the specialist utensil they required. The cutlery had subsequently broken in the persons mouth when they attempted to use this to eat, causing the person to vomit. They had then required emergency suctioning and paramedic assistance due to the possibility that they had swallowed pieces of the broken cutlery.

Other non-direct support staff worked at the service, including administration staff. These staff members were not required to support people in any capacity. During the inspection an untrained administration staff member picked up a cup with a straw that was sitting on a person's table and put the straw in the person's mouth. They then walked away before the person had finished drinking. The person had not indicated that they would like to be supported to have a drink. Their care plan confirmed this was inappropriate and that the person could pick their cup up and drink from the straw independently once the cup was on their table.

There were systems in place to help manage the risk that people may receive unsafe foods. Meals were

prepared in a central kitchen by separate catering staff. The chef had a copy of eating and drinking guidelines for all people about what they could and could not safely eat and if their food required specialist preparation to make it safe. For example, by pureeing meals or making sure food was soft enough to be mashed. Meals were prepared and plated individually according to these guidelines and sent out in named dishes. Where required meals were pureed in advance by the chef, but if people required their foods to be cut up, smashed or mashed this was expected to be done by the staff supporting them after the meals arrived from the kitchen.

However, not all agency staff had read people's eating and drinking guidelines. Guidelines available for all staff, including the chef, were not always recently reviewed, contain best practice guidance and sometimes included several documents with different directions and levels of detail. This increased the risk that people might not get the correct support when preparing their food and could receive inappropriate foods of an unsafe consistency.

Staff completed records of everything people had eaten to monitor this risk and check that people had not had unsuitable or unsafe food, according to the guidelines available. However, staff were not recording on food monitoring charts that the food people received was of a safe consistency according to their assessed needs. For example, for people who required food to be mashed or cut up, this was not recorded on their food charts and they contained examples of foods that would not be safe for people to eat if this was not done. This meant that it was not possible to know or evidence that people's food had been prepared correctly or they had been given the right support to receive their food in the correct form.

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

At the last inspection we found that NEWS systems in use at the service to monitor people's health needs was not effective. There was insufficient guidance about how to use NEWS correctly. People's individual baseline health indicators had not been established, not all staff understood how to use the NEWS system and people's NEWS scores were not being completed consistently. Where NEWS had been completed and scored and results showed that action to seek further medical attention was needed, this was not always done. This placed people at high risk of potential harm. At this inspection we looked to see if the provider had made necessary improvements to address this issue.

Changes to the NEWS system had been implemented very shortly prior to the inspection. Some permanent registered nurses had now received additional training in how to use the NEWS system, including scoring and analysing information and what action to take according to the results. Individual baselines of people's normal health indicators had also very recently been established and made available for staff. People's NEWS charts had been completed more consistently. There was a recent example since the changes had been put in place where staff had sought further medical advice following analysis of people's NEWS scores indicating that this was necessary.

However, an agency registered nurse working during the inspection told us they were still not confident how to score and analyse people's NEWS observations and when they might need to act to get further medical attention to keep people safe. The service employed several agency registered nurses regularly as they were currently short staffed. Agency nurses working at the Laurels did not attend the provider's formal internal NEWS training. The provider and registered manager could also not confirm that any informal support and

explanations about how to use NEWS had been given to agency nurses working at the service. Agency nurse profiles did not show that they had received external training in using the NEWS system before starting work at the Laurels. The service relied on NEWS as the primary pathway for effectively monitoring people's health and keeping them safe. By not ensuring that all staff knew how to follow this pathway, this increased the risk that people may come to avoidable harm.

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

At the last inspection we identified systems and processes to prevent and learn from safety incidents and safeguard people from abuse were not operating effectively. Not all accident and incidents and safeguarding concerns had been reported internally or externally. Opportunities for lessons to be learnt or actions taken in response to incidents had not always occurred and people continued to be at risk of unsafe care or abuse. At this inspection we looked to see if the provider had made necessary improvements to address these issues.

There was an accident, incident and safeguarding reporting system. Staff recorded incidents on forms which were reviewed by the manager and deputy manager and clinical lead. This system was designed so the management review could help ensure immediate preventative action was taken to keep people safe. Management then completed separate 'Untoward Event Reporting Forms'. These forms were then shared with senior management and quality audit officers within the organisation for further review and to help make sure actions were delivered and lessons were learnt to avoid future incidents.

Staff had received training and support to recognise safeguarding concerns and know how to use the forms and report incidents. Accident and incidents and safeguarding concerns had been completed more consistently by staff. However, not all staff understood their responsibilities to report incidents or make sure that if an incident occurred this was reported as soon as possible. This meant adequate reviews and actions to keep people safe had not always occurred in a timely manner.

For example, an incident had occurred where a person was noted to have suffered bruising. This was not reported internally for 17 days. The provider's analysis of the incident concluded that the bruising may have been caused by staff incorrectly fitting the person's postural equipment. Due to the delay in reporting, this meant actions to review equipment and provide further support for staff to prevent the risk of this occurring had not been taken immediately, leaving the person at risk of avoidable harm for this period.

On another occasion a person needed support to have a regular injection of a medicine. They had not been given their medicine on the day it was required due to staff error. This error was not recognised by registered nurses until four days after the date the medicine was missed. Action was then taken to seek medical advice and arrangements made to ensure that the person then got their medicine as required. However, there had then been a further delay of 19 days before this incident had been reported to management so they could review this with staff, look at what went wrong and how to prevent this error from re-occurring in future.

Where incidents and safeguarding concerns had been reported internally without an undue delay, information about safeguarding concerns and incidents and accidents was not always shared with partnership agencies by management. Where this had been shared, this had not always been done in a timely manner. This meant further review and investigation to agree all necessary actions keep people as safe as possible did not always happen quickly or at all.

For example, there had been an incident where a person not previously assessed as being at risk of choking had done so while being supported to eat. The person had required emergency action from staff to dislodge food, followed by an emergency hospital admission. Staff had not reported this to the local authority to inform them an incident that affected the health, safety and welfare of a service user had occurred. There was then a delay of 13 days before the person's eating and drinking risk assessment had been reviewed internally to make guidance available for staff about how to reduce the risk of the person choking again. Staff had reported the incident to a GP requesting for specialist SaLT review of the person's eating and drinking needs but had not taken steps to contact SaLT directly. The indirect referral was not followed up by the service, meaning there had been a delay of 35 days before SaLT had become aware of the incident. When made aware of the incident, SaLT then identified the internal risk assessment the provider had put in place following the incident was not fit for purpose. This meant the person had remained at risk of avoidable harm for this period.

SaLT then arranged the necessary review to put in place more substantial actions to keep the person safe. The local authority had then been informed of the incident and the delay in taking reasonable action to make sure the person was safe. A multi-agency safeguarding investigation was then commissioned. This meant there was a delay of 44 days after the original incident before an appropriate multi-agency review was undertaken by competent staff to look at further actions and learning about how to prevent these risks reoccurring in future.

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 there were there were on-going issues with providing sufficient numbers of suitable staff. The service was under-recruited but had taken steps to ensure that temporary agency staff were available to cover the vacancies. They had increased the level of support and training for permanent and agency staff to make sure they had the right skills and experience to meet people's needs safely.

The provider had implemented a company-wide service review to re-assess people's support levels to make sure they were getting the correct amount of support they were funded for. This had resulted in an initial reduction of overall staffing levels at the service. Staff raised concerns with us about the reduction in staffing levels leaving some people at risk of not meeting their needs. The provider had restored staffing levels in response to the concerns while the review was on-going. At this inspection we checked to see that the service had sustained these improvements and if staffing levels were sufficient to meet people's needs safely.

The service was still under recruited and the provider relied on agency staff to fill the vacancies until they could be permanently recruited to. A person's relative told us that they had concerns there were "Not enough ground staff, there are too many higher management positions and they need more staff on the floor." On the day of the inspection there was only one registered nurse to cover the entire service due to planned agency staff cover illness. The manager explained that if no alternative agency or permanent staff cover could be found in this situation, the service had an arrangement to use staff who worked at nearby services operated by the provider. The manager and staff and arranged for cover to arrive within a couple of hours.

Rotas confirmed that, according to the organisation's staffing calculations, being short staffed was a relatively isolated incident. Staff had again recently raised further concerns about reduced staffing levels meaning people could not take part in social activities and it was sometimes taking longer to complete personal care tasks for people. This had resulted in more staffing being allocated on shifts until the service

review had been completed and the final staffing levels were agreed.

Permanent and agency staff continued to receive more comprehensive inductions. Staff were offered on-going training to make sure they had the right skills to support people. Some staff training was not yet completed or required updating. Staff told us that further training was being arranged for them. If they were not confident to deliver support to people before any outstanding training had occurred, their rotas were designed to always have a member of staff available who did have the right competencies and experience available.

At the last inspection people who required support to manage the risks of dehydration had not always been supported to establishing a recommended daily allowance (RDA) of fluids to manage this risk. Where an RDA had been established, it was not always recorded people had received this. If it was recorded that people had not had their RDA, there was no evidence that concerns had been raised or that any action had been taken in response.

At this inspection we looked to see if the provider had made significant improvements to address this issue. People's fluid charts had been updated to include RDAs where these had been missing. This helped staff to know how to be sure people were getting enough fluids. Apart from one isolated incident, charts showed that people were consistently receiving their RDA of fluids. There were messages to staff from management in internal communication books to remind them of the importance of making sure people received their RDA of fluids. Staff were aware of people's fluid RDAs and people were regularly supported to drink throughout the inspection. This reduced the risk of people suffering harm due to becoming dehydrated.

Inadequate

Is the service well-led?

Our findings

People said they liked living at The Laurels. Two people's relatives said although there had been past issues with the management of the service, recent changes made them feel more confident the organisation would be able to deliver consistent high quality and person-centred care.

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

Recently revised quality assurance and governance systems continued to be in operation. Daily, weekly and quarterly audits by staff, management and the provider's internal quality team took place. There were several development plans in place, which included actions based on reviews of the results of the different audit processes. Some of the development plans included timeframes for actions to be completed by, others did not and were considered on-going. Plans were shared at middle and senior management level for further oversight. The provider had allocated internal quality support staff to work with staff and management on-site until quality and safety issues had been resolved. Current staffing structures had been revised and new posts had been created within the local staff team to support the delivery of expected standards of care.

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

For example, issues regarding preventing and learning from safety incidents, failing to safeguard people or operate effective quality assurance systems and governance frameworks have been identified as inadequate or requiring improvement in consecutive CQC inspections since May 2017. A development plan to address these issues was written in July 2017 and shows actions including more robust service manager and quality team audits and a more intensive weekly organisational senior management and Director of Quality 'Watchlist' review of incidents. This was designed to support the service manager to ensure that quality monitoring and auditing systems are more effective.

The 'Watchlist' review of service quality at the Laurels shows that actions needed to ensure effective quality assurance systems are in operation were completed by July 2018. A quality team audit in August 2018

confirms that all staff understand their roles and associated responsibilities to raise immediate concerns internally and externally, and take necessary actions, in response to safeguarding concerns and safety incidents. These audit findings have been reviewed and signed off as complete by the organisation's Director of Quality in August 2018.

However, actions passed as complete in these quality reviews do not correspond with the findings from this inspection. For example, evidence reported in the 'Safe' domain show areas of staff practice and understanding regarding safeguarding people, undue delays in reporting and failure to act to prevent and learn from safety incidents are not compliant with Health and Social Care Act 2008 regulations. The revised audit processes therefore do not demonstrate a competent understanding of what is required to deliver expected standards of quality performance, risk management and regulatory requirements.

At the last inspection, we identified concerns regarding ineffective partnership working on behalf of the provider, including failure to share information to support safe care provision on behalf of people who use the service. At this inspection we checked what improvements had been made in this area of practice.

Prior to this inspection, the local authority raised concerns regarding ineffective partnership working by the provider, including failure to share information about people's care. Findings from this inspection showed some increase in communication between the provider and key external agencies. However, there had been significant undue delays in information sharing about people's care in response to incidents and safeguarding concerns. Immediately following this inspection, we received feedback from local authority and healthcare professionals that management and staff at the service had not always worked in an open and transparent way when recently approached to review people's care. This increased the risk that people may not receive the best quality of care. It also reduced the ability of the service and partnership agencies to learn from each other about how to improve people's overall care provision.

The failure to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved and the service worked in partnership effectively with other agencies is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There has not been a registered manager at the service since February 2018. A manager had been appointed in June 2018 and was currently fulfilling the role and responsibilities of the registered manager. The manager was currently in the process of applying to be registered with CQC. Prior to their appointment an interim area manager had been fulfilling the registered manager responsibilities.

At the last inspection, we identified that all legal requirements of the service had not been met as expected, including submitting statutory notifications. At this inspection we checked what improvements had been made to ensure legal requirements were fulfilled, including regulatory breaches.

The registered provider's governance framework had continued to be ineffective in ensuring that all legal requirements of the service were met as expected. This included submission of CQC statutory notifications. Although there had been a relative increase in the number of notifications CQC had received since the last inspection, these had not always been submitted to the CQC as required. This included failure to notify the CQC regarding allegations of abuse via neglect and acts of omission which may cause harm or place at risk of harm. For example, incidents relating to medicine errors where people had not received their medicines as intended.

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

The manager remained committed to supporting staff to be able to deliver their vision of high quality person centred care for people. Although formal staff meetings and supervisions were not yet always taking place regularly, the manager aimed to maintain a visible presence to offer opportunities for staff to share and understand information about what was expected when delivering people's care and any quality or safety risks. Staff confirmed the manager was approachable and they and senior staff were always available to ask and give advice about the expected standards of care and how they could best achieve this in their roles.

Relatives told us they had been encouraged to attend meetings and share feedback with the provider to help identify what was and as not working well at the service. One relative said, "I feel my comments have been listened to. There have been lots of changes of management. There seems to be a recent attitude of 'let's get things right' from the new manager which feels positive." Another relative told us that despite issues with management and administration they felt there was a caring ethos at the service and staff displayed these values.

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 12 (1) (2) (a) (b) Failure to do all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users.

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 13 (1) (2) (3) Failure to ensure service users were effectively safeguarded from abuse and improper treatment

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 17 (1) (2) (a) (b) (c) (e) Failure to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved and the service worked in partnership effectively with other agencies.

The enforcement action we took:

We imposed conditions on the provider's registration.