SHC Rapkyns Group Limited

The Laurels

Inspection report

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27 February 2019
28 February 2019
01 March 2019
21 March 2019

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:

●The Laurels is a residential care service that is registered to provide accommodation, nursing and personal care for up to 41 people with the following support needs; learning disabilities or autistic spectrum disorder, physical disabilities, sensory impairments, younger adults.

●At the time of this inspection The Laurels was providing support for 14 people.

● The Laurels is owned and operated by the provider Sussex Healthcare. Services operated by Sussex Healthcare have been subject to a period of increased monitoring and support by local authority commissioners. Due to concerns raised about the provider, Sussex Healthcare is currently subject to a police investigation. The investigation is on-going and no conclusions have yet been reached.

● The Laurels had been built and registered before the CQC policy for providers of learning disability or autism services 'Registering the Right Support' (RRS) had been published. The guidance and values included in the RRS policy advocate 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.

● The Laurels requires further development to be able to deliver support for people that is consistent with the values that underpin RRS. For example, care planning processes did not always consider people's personal information and how these informed their individual support needs and wishes, people did not always agree, review or develop their support goals and people could not always take part in meaningful activities or have regular access to the community.

People's experience of using this service:

● Medicines were not always being managed safely.

● Risks to people were not always assessed, monitored and managed safely.

● Lessons were not always learnt and improvements made when things had gone wrong at the service.

● There were not always suitably trained staff deployed and the service did not always make sure that staff had the skills, knowledge and experience to deliver effective support.

●People's needs and choices were not always assessed so staff knew and understood how to deliver support for them to achieve effective outcomes.

●Staff, teams and services did not always work together well to deliver effective support for people.

●People did not always receive personalised care that was responsive to their individual needs.

●Information about people's care and treatment was not always made available in the most accessible way for people.

●Quality assurance and governance systems were not operating effectively and were not supporting staff and management to understand their responsibilities and ensure that quality performance and risks were understood and managed.

● We received mixed feedback directly from people using this service.

● Two people we spoke with said they did not feel safe and one person raised specific concerns about unsafe staff practice. Six other people we spoke with said they liked staff, felt safe and liked living at the Laurels.

● Most people we spoke with said they liked staff and they were kind, however some people said staff were not always caring. Not all people we spoke with said they felt staff knew them, listened to them and respected their choices.

● People were aware of how to make complaints, but not all people said they received appropriate responses when they had done so.

● People said they were not always being offered support to take part in activities they wanted and go out of the service but that this was improving recently.

●We have made a recommendation that the provider introduces appropriate support and accessible information for people using the service about understanding abuse and discrimination.

● This inspection identified continued breaches of Regulations 9, 10, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Rating at last inspection:

● There had last been an inspection of The Laurels in 10 October 2018, the report for which was published on 5 February 2019. This was a focused inspection that looked only at the key lines of enquiry (KLOE), Safe and Well-Led. Both KLOE were rated Inadequate and the overall rating for the service was therefore also Inadequate.

● The Laurels had been rated overall Inadequate in the four previous inspections that had taken place at the service between February 2018 and October 2018.

● At each of these four consecutive inspections there have been multiple and repeated breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified.

● The Laurels has been placed in Special Measures since April 2018. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. Services in Special

Measures will be kept under review and, if needed could be escalated to urgent enforcement action.

Why we inspected:

● This inspection was scheduled and planned based on the previous rating to explore if the provider had acted to significantly improve the service to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enforcement:

●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, due to repeated and significant concerns about the quality and safety of care at several services they operate. The conditions are therefore imposed at each service operated by the provider, including The Laurels. 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.

Follow up:

●The overall rating for this service is 'Inadequate' and the service remains in Special Measures. Services in special measures will be closely monitored and are expected to make significant improvements to ensure their rating is at least good. Where necessary, another inspection will be conducted within or before a further six months. 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not always effective

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

The Laurels

Detailed findings

Background to this inspection

The inspection:

● We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions.

● This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

● This inspection took place over four dates; 27, 28 February and 1 and 21 March 2019. The members of the inspection team for these dates were as follows:

● On 27 February there were two inspectors, a learning disability nurse specialist advisor, a pharmacist inspector 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.

● For the visit on 28 February there were two inspectors and a learning disability nurse specialist advisor.

● For the visit on 1 March there were two inspectors.

● For the visit on 21 March there was an inspector and a medicines inspector.

Service and service type:

● 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 service should have a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

● The service had recruited a manager to permanently fulfil the registered manager's role at the beginning of June 2018. At the time of the inspection, the manager was in post and in the process of formally registering with the Care Quality Commission (CQC). The manager's registration was approved shortly following the completion of the inspection.

Notice of inspection:

● This inspection was unannounced.

● Inspection site visit activity started on 27 February 2019 and ended on 21 March 2019.

What we did:

● 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.

● Prior to the inspection we reviewed other information we held about the service. We considered the information which had been shared with us by the local authority, other agencies and health and social care professionals. We 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.

● We spoke with eight care staff and one activities staff, four registered nurses, the clinical lead, the acting deputy manager, the service manager, the regional operations manager, the autism and positive behaviour support lead, the engagement and involvement manager, the safeguarding lead and the quality support manager.

● We spoke with an external change management consultant and a quality support consultant, both of whom were being contracted to work with management and staff at the service.

● We 'pathway tracked' six 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 six people's relatives.

● We observed people's support across all areas of the service.

● We reviewed 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

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

● Some aspects of the service were not always safe and there was limited assurance about safety.

● People were at risk of avoidable harm.

● Some regulations had not been met.

Assessing risk, safety monitoring and management, using medicines safely, learning lessons when things go wrong

● At the last inspection we identified that the provider was not doing all that was reasonably practical to mitigate risks regarding choking, aspiration and people's on-going healthcare support needs and provide safe care and treatment to service users. There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to this inspection we had received notifications from the provider and information from other sources that indicated risks to people regarding choking and aspiration, skin integrity, postural support and on-going healthcare support continued not be managed or monitored safely.

● At this inspection we looked at how these areas of care were managed. We also checked if the provider had made necessary improvements since the last inspection regarding assessing, monitoring and management of risks and if this breach of regulations had been met.

● Most people living at The Laurels had been identified as being at risk of choking or aspiration due to swallowing difficulties known as dysphagia. There had been substantial additional support from specialist community speech and language therapist (SaLT) teams to help assess and provide guidance about how to manage these eating and drinking risks. This input included re-writing risk assessments and care plans so they contained relevant and up to date information about how to keep people safe.

●However, people continued to have several different risk assessments and care plans available for staff, including documents written both internally and by SaLT. These documents had not always been reviewed, did not always have the same amount of detail as each other and in some cases contained conflicting directions or incorrect information. Different documents were in different places meaning they were not easily available or accessible for staff. This increased the risk that staff would not know how to manage these risks and support people safely to avoid the risk of choking and aspiration.

● For example, one person had several different directions and guidelines available, some requiring review and all containing different levels of detail and inconsistent advice about how to support them to manage the risk of aspiration and receive their PEG feed safely, including how to position their body when receiving

this support. PEG is an abbreviation for percutaneous endoscopic gastrostomy (PEG) tube. This is a tube that is inserted into a person's abdomen so they can receive liquid food, fluids and/or medicines directly to their stomach.

● The person had one set of PEG feeding guidelines from their care plans that included directions to position and feed the person in an unsafe way, placing them at risk of harm from aspiration. The person had a different set of PEG feeding guidelines that had been stuck to their bedroom wall. These directions gave advice that, if followed, would mean the person received support to manage the risk of aspiration as safely as possible.

●The person's feeding and positioning charts showed the person had been supported according to the directions in their care plans and that they had been consistently receiving their PEG feed in an unsafe way. When this was raised with the provider, the regional manager told us staff had told them that they had been following the guidelines that had been stuck to their bedroom wall and the person had been supported safely, despite this not being reflected in the person's records.

●Other people had duplicate choking and aspiration risk assessments available, some of which did not consider relevant information about their postural support needs or mental capacity. This meant that some of the identified actions in their risk assessment, designed to reduce the risks would not be effective in practice and could potentially cause the person harm.

●For example, one person's choking protocol stated that in the event of a choking incident staff should encourage them to cough several times to clear their throat, followed by five backslaps and five abdominal thrusts. However, due to their mental capacity, the person would not understand or respond if you asked them to cough. The person had a physical disorder where the spine twists and curves to the side. Due to this, it would not be appropriate to administer abdominal thrusts as the thrusts may not be effective and may cause the person harm. Staff who spoke with inspectors confirmed they would not follow the directions in this person's risk assessment for these reasons.

●This issue was raised with the provider on the first day of the inspection, and a member of the inspection team was shown an updated choking protocol for the person on day two by the Clinical Lead at the service. However, despite the document being reviewed by the Clinical Lead, part of the updated protocol continued to state that staff should carry out abdominal thrusts on the person if there was a choking incident.

● In some people's choking risk assessments there was reference to staff needing to use a de-choker device to prevent serious injury or death in the event of a choking incident. However, at the time of the inspection, 11 out of the 24-permanent staff who supported people with eating and drinking had not received training to use the de-choker device. The service was currently using approximately 43% agency staff to backfill staff vacancies. This included a regular contingent of 55 agency care assistants and eight agency registered nurses. Of these, only four regular agency staff members had received de-choker training.

● Although the service deployed at least one trained staff member per day shift, there were sometimes no trained staff members deployed during the night shifts. There was a lack of available trained staff in the event of existing trained staff becoming unavailable. This left people at risk as not all staff knew how to use this equipment safely.

●Risks associated with choking have been highlighted in inspection reports about a number of the provider's other services. This information had not led to similar risks to people at The Laurels being

properly reduced.

●Due to their physical disabilities, most people living at The Laurels required support to manage postural and skin integrity risks. People had support from internal and external physiotherapists and staff used recommended clinical tools to estimate the level of risk for individuals. This resulted in assessments and care plans that were available for staff to follow that identified actions needed to keep people safe and reduce the risk of injuries occurring.

●However, people had several different skin integrity risk assessments and care plans available for staff. Some of these did not always have documented reviews and contained different and conflicting or inconsistent information, increasing the risk staff would not know how to support people safely. Staff were not always following guidelines and ensuring that identified actions were taken to safely manage people's postural and skin integrity support needs.

●For example, one person had suffered friction injuries and it was identified that staff were not supporting them safely to use their postural support equipment. The person's skin integrity risk assessments did not consider or reference their guidelines about how to safely manage the risk of friction injury when supporting them with their daily postural support equipment. No review had taken place to amend their skin integrity care plans and risk assessments to include this important information about how to keep them safe.

●Another person had been assessed and had identified actions to support them to manage the risk of decreased mobility and discomfort. This included weekly hydrotherapy and twice weekly walking and standing frame sessions. A registered nurse (RGN) and support staff confirmed this person's hydrotherapy sessions had not been undertaken, "for some time now." The RGN and staff were not sure that the person's twice weekly standing and walking frame support was always taking place or who was responsible for carrying this out. They told the inspection team they thought physiotherapy technicians usually carried out this out and "they sometimes visited at weekends."

●The same person had care plans and risk assessments which stated the need to wear special aids to improve mobility and manage risks of decreased mobility and discomfort. The person was observed to not be wearing their aids. When asked, the RGN reported that these had been sent for repair but could not say when or when these would be returned. No alternative had been sought, placing the person at risk of discomfort and decreased mobility.

●Some people living at The Laurels required specialist equipment to support them to move and reduce skin pressure risks associated with their mobility needs. This included hoists, slings and air mattresses. Staff carried out regular checks and where applicable there was annual servicing of equipment. However, these checks were not always effective and had not always identified where equipment had been defective. This equipment had remained in use while not fit for purpose, leaving people at risk of harm.

●One person's air mattress was not switched on as it should have been during a visit on 27 February 2019. We received information from the provider and the local safeguarding authority between the visit on 1 March and 21 March that the same person had sustained pressure damage due to their air mattress pump being faulty and not working.

● We last inspected how medicines were being managed and used at The Laurels during a focused inspection in August 2018. We had identified that use of medicines was not safe and there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to this inspection, we reviewed information from the provider and other sources regarding on-going unsafe use and management of medicines at the service, including several recent medicine errors that had exposed people to avoidable risk of harm.

● At this inspection, we checked if people were at risk from unsafe management and use of medicines and if the breach of regulations had been met. Due to concerns identified during the visits on 27 and 28 February and 1 March and the receipt of further medicine error notifications following these dates, we carried out a further visit on 21 March to see if improvements had been made.

● There were systems to help ensure medicines were ordered, stored, disposed of and administered safely. There were daily, weekly and monthly checks and audits of these systems. Staff received medicine training. There had been changes made to internal medicine policy and procedures to specify how medicines should be used and managed safely in line with best practice guidelines.

● External pharmacy visits were being carried out in line with the imposed condition. An internal Quality Manager had been deployed since August 2018 specifically to support the manager at The Laurels on an on-going basis to oversee systems operation, implement policy changes and internal and external audit recommendations regarding safe and proper use of medicines.

●Despite this, medicine errors had continued to occur at The Laurels since August 2018 up to the date of the first inspection site visit on 27 February 2019. Between 1 January and 25 February 2019 there had been nine medicine errors. We received notifications of a further four medicine errors occurring at the service between the site visit on 1 March and the site visit on 21 March 2019. These errors had resulted in people not receiving their prescribed medicines as intended, including missed medicines, late administration of medicines and a person receiving overdoses of their medicine for an extended period.

●The errors included medicines used to treat conditions associated with individual's specific health conditions including; thyroid hormone deficiency, muscle spasms and spasticity, epileptic seizures, constipation, osteoporosis, high blood cholesterol and gastroesophageal problems. For some people, there had been repeated missed medicines over the period of the three months up to and including March 2019.

● Since August 2018, external pharmacist recommendations had not always been acted on in a timely manner or at all. Internal medicine daily, weekly and monthly checks and audits had not been completed consistently since the last inspection. Where audits had been completed, recent weekly and monthly audits from January and February 2019 showed systems regarding ordering, storing, disposal, recording and administration of medicines were not operating effectively. Recent audits from January and February 2019 identified repeat errors and issues in all these systems and a lack of staff understanding of how to operate them.

●RGNs were responsible for administering and managing all aspects of medicine support at the service. To ensure that they would be able to fulfil this responsibility safely, management and clinical staff were expected to carry out medicine competency assessments and on-going observations up to twice weekly with the RGNS.

●Competency assessments had not always been completed or commenced for all RGNs working at The Laurels. Where assessments had been completed, records showed that this was not taking place regularly. This meant the service could not assure themselves that all staff were competent to administer and manage medicines. This left people at risk of avoidable harm. For example, following some medicines errors the

RGNs responsible for administration had not received any competency checks. Further errors involving the same RGNs had then occurred.

●During the visit on 21 March 2019 the manager confirmed that the most recently completed competency assessments had taken place in September 2018 for permanent staff and that more recently commenced competency assessments for agency staff had been started on 21 February 2019 and were all incomplete.

●People did not always have accurate, up to date or detailed protocols for when to offer and administer any prescribed 'as and when required' (PRN) medicines. This increased the risk that people may have too much or too little PRN medicines or that they may be administered where it was not necessary.

● People had their own Medication Administration Records (MARs). Some people's MARs were not clear and accurate and required more detail about how their medicines were taken or used and how often.

●For example, the time and route of administration was not included on MARs for people who required they receive their medicines at specific times or via certain routes. MAR had not always been completed accurately to record when medicines had or had not been administered. This increased the risk that people may not be receiving their medicines as intended and were being exposed to avoidable harm.

●At the last inspection we identified that staff and management were not always learning lessons and making improvements when things had gone wrong.

● At this inspection, we checked if people were at risk and if the provider had made necessary improvements.

●The provider continued to operate several different systems to enable them to report, review and investigate safety and safeguarding incidents. These systems included completion of 'Untoward Event Report' (UTE) forms by staff and management, the content of which would be shared with senior management and other internal staff such as the 'Quality Team' for weekly and monthly analysis of themes and trends.

●Although there had been an increase in staff and management reporting incidents internally and externally, including safeguarding concerns, the UTE reporting system was not always effective.

●Staff told us and service records showed safety incidents being reported which the manager confirmed they were not aware of and for which the specific incident report could not be immediately located. Provider notifications received pre-inspection about safety incidents, near misses and safeguarding events did not always have a completed UTE.

● A sample of UTEs and management trend analysis documents completed since the last inspection showed either very minimal or no information at all regarding how events had been reviewed, investigated and what actions had been taken to prevent a recurrence. The manager and staff were unable to provide examples or other information to show what actions had been taken in response to incidents and how effective these had been.

●Where safety incidents had been externally and internally reported there had not always been appropriate review and investigation and it could not be seen that all reasonable action was taken to prevent a re-occurrence and make sure that improvements were made. Where repeat themes were evident in safety

events at The Laurels, lessons had not been learnt and learning from similar occurrences at other services had not been effectively shared or considered.

●For example, a person had been hospitalised in January 2019 with suspected aspiration pneumonia. The person required complete support to manage their eating and drinking via PEG and to be positioned correctly when receiving their food. This category of event involving people with complex eating and drinking needs suffering from aspiration pneumonia had been the subject of serious concern preceding and following the last inspection at The Laurels.

● Staff told us and there had been recorded concerns that the person may be at risk of aspiration before and after they were hospitalised, but these concerns had not been reviewed or acted on to reduce this risk of this occurring or happening again. A review of the person's postural and eating and drinking records and support plans identified the person's current support exposed them to risk of aspiration and appeared to show them being supported in unsafe ways.

●In response to us bringing this concern to their attention, staff at the service took immediate action to mitigate this risk.

● 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. Staff were expected to complete NEWS once a month as a precautionary measure and as and when required if noticing a person appeared or was unwell.

●At the last inspection we identified that not all staff knew how to use the NEWS system. At this inspection we checked to see if the provider had made necessary improvements to ensure that staff knew how to do this.

●NEWS charts were being completed monthly and as and when required in line with the service policy. There were examples of where staff had scored the NEWS correctly and acted appropriately in response. However, not all staff had received the necessary training to use the NEWS systems. People's NEWS charts showed they had not always been completed as required. We saw that one person required physical monitoring on being prescribed antibiotics for a chest infection. We saw that NEWS monitoring was undertaken once following the diagnosis and then not completed the following day. A day later a written plan was in place requesting twice daily NEWS monitoring. However, records showed that this twice daily NEWS monitoring had not been carried out as required.

●These examples show that people continued to remain at risk that their healthcare needs may not be monitored or escalated appropriately.

● The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users, ensure safe and proper use of medicines and thoroughly review, investigate, monitor and make sure remedial actions and improvements are made in relation to incidents that affect the health safety and welfare of service users or have adequate arrangements to respond appropriately to people's changing healthcare needs. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

●There had been an increase in staff vacancies since the last inspection. The service was relying on a high percentage of agency staff to cover shifts while permanent staff were recruited.

●Rotas had been written to allocate staff, based on the provider's calculations of the levels of support people needed. People and staff told us although there was a high use of agency staff there were enough staff to support people safely. We observed that apart from one shift on the first day of our inspection, staffing levels corresponded with the provider's calculations. These staffing levels appeared to provide enough staff to meet people's needs.

● All agency staff working at the service had undertaken a satisfactory Disclosure and Barring Service (DBS) check, in line with the provider's recruitment policy. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting. Staff had submitted applications, references and completed an interview prior to being offered work at The Laurels.

● Management had recently introduced a more comprehensive agency staff induction process. This had been expanded to include more detail about relevant safety systems, processes and practices relating to people's needs. Staff told us and we observed that permanent staff spent sufficient time covering the induction with new members of agency staff and offered more supervision while working alongside them.

Systems and processes to safeguard people from the risk of abuse

● We received mixed feedback from people about their safety. Some people said they felt safe. One person said, "I do not worry here". However, two other people said they did not always feel safe and one person raised specific concerns about unsafe staff practice and we raised this with the provider.

● At the previous inspection we identified the service was not ensuring service users were effectively safeguarded from abuse and improper treatment and there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● At this inspection we looked to at the concerns raised and to see if people were at risk of harm. We looked to see if the provider had made necessary improvements since the last inspection regarding safeguarding people from abuse and improper treatment and if this breach of regulations had been met.

● We found the breach of regulations had been met. All staff had received training and support to recognise safeguarding concerns and knew how to recognise signs of abuse, including discriminatory abuse. Staff understood their responsibilities to report concerns as soon as possible and how to do this. Records showed this had been done more consistently and in a timely manner since the last inspection.

● Where safeguarding concerns had been reported internally involving people and staff at the service, the manager had reported these externally. Investigations, reviews and actions were in progress or had been undertaken both independently by the provider and in partnership with other agencies such as the local authority safeguarding team.

● Although staff said they would talk to people if they had concerns about their safety, people did not have accessible information or specific support to help them understand and be aware of different types of abuse, including discriminatory abuse.

● This increased the risk that people might not be able to understand or recognise all types of abuse situations and be empowered to know what they could do or who they could speak with, both inside and outside of the service, to raise concerns and get help to stop and prevent abuse occurring.

●We recommend the provider introduces appropriate support and accessible information for people using the service about understanding abuse and discrimination and what they can do about this to stay safe.

Preventing and controlling infection

● The service was clean and hygienic. The provider employed separate cleaning staff who carried out daily cleaning within all areas within the Laurels. Plastic gloves and aprons where available and staff used these 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 to help ensure food was handled and prepared safely.

Requires Improvement

Is the service effective?

Our findings

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

●The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

●Some regulations were not met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

●We last inspected how people's needs and choices were assessed at The Laurels in June 2018. We identified that there was a lack of a holistic assessment process and people's social and psychological needs were not always considered in enough detail. There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●At this inspection we looked to see if the provider had made necessary improvements and if the breach of regulations had been met.

●We were told by the manager and regional operations manager that there had been no changes to the assessment process since the June 2018 inspection. They acknowledged the need to improve in this area and told us that they planned to look at how staff and people could be more actively involved in the assessment process to ensure people's needs and choices were considered more holistically and staff could deliver more effective support.

●However, it remained that people's social and psychological needs had not been comprehensively re-assessed and were not being considered in detail when delivering their support. This increased the risk that their preferred outcomes would not be identified or achieved or that their support would not be delivered in line with best practice evidence based guidance.

●For example, the Autism and Positive Behaviour Support (PBS) lead told us that the continued lack of detailed information about people's social and psychological needs was affecting their ability to provide staff with relevant direction and best practice guidance about how best to support people who may display behaviours that challenge, to achieve effective outcomes.

●They gave an example of how they were in the process of carrying out functional assessments for people at the service with behavioural support needs but had been unable to complete these to date. They said, "There is so little information available about people, I didn't know the person or how to motivate them". This meant staff were unable to support people in the most effective way to help them achieve their behavioural and other corresponding support needs outcomes.

● The failure to assess and design care and treatment with a view to achieving service user's preferences and ensuring their needs are met is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

●We last reported on how the service was making sure staff had the right skills, knowledge and experience to deliver effective support in June 2018. We identified that permanent staff had not received appropriate support and training. There was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●At this inspection we looked to see if the provider had made necessary improvements and if this breach of regulations had been met.

●We received mixed feedback about whether staff had the right skills, knowledge and experience to meet people's needs safely. People said they thought permanent staff knew how to meet their needs but some people raised reservations about the competence of agency staff. One person said "I have ones I do not know sometimes. I don't like this."

● The service was regularly using eight agency RGNs and 55 health care assistants (HCAs). Many of these staff were allocated shifts on rotas in advance and were regularly working full time equivalent hours on a month by month basis.

●Training records for these agency staff showed that both RGNs and HCA had training in need of renewal and not all agency staff had received the same training from their respective agencies.

●For example, some agency nurses' records did not show they had received training in subjects relevant to supporting people at the Laurels safely and appropriately. This included key areas of practice such as; equality and diversity, health monitoring tools and systems, autism and learning disability awareness, PEG, epilepsy awareness, mental capacity and DoLS. HCAs training records also showed similar discrepancies in training received, including learning disability and autism awareness and equality and diversity. Four agency nurses had received further training in one or two subjects and none of the HCAs had been provided with any further training.

● Beyond the initial induction, agency staff did not receive any on-going formal supervision from staff or management at the service. If safety incidents or practice and disciplinary issues occurred, there was no expectation beyond informal discussions that the provider would formally supervise or manage agency staff to address these issues. This increased the risk that agency staff without sufficient skills, knowledge or support might be regularly deployed and people may not have their individual needs met effectively.

●For example, one person told us about their concerns about agency staff saying, "They don't always come right away. I wait and don't always know them at night and some say I don't need help and they don't come much". A sample of recent rotas from February 2019 showed agency RGNs were regularly deployed over a seven-day period to cover approximately 40-50% of day shift and up to 100% for night shift overall staffing allocations. HCAs were also deployed to cover similar percentages of staffing allocations over day and night shifts.

●A recent safeguarding investigation had confirmed poor practice by agency night staff in relation to abuse

allegations. However, there was no disciplinary action or further supervision arrangements made by the provider to support these staff to improve their practice, including the provision of additional or refresher training. The agency staff continued to work at night when there is no management presence and very high levels of agency staff, meaning that as well as being informal, on-going supervisory checks will be minimal and mainly reliant on other agency support staff's informal observations.

●Permanent staff were expected to receive regular supervisions of their practice during and after their initial probation period and complete training specific to the assessed needs and choices of people. This included subjects such as autism and learning disability awareness, equality and diversity and mental capacity act and deprivation of liberty.

●However, training records showed that several staff had not completed or received this specific training. Staff records showed that there had not been regular supervisions of their practice, in line with the provider's policy. From six staff files we sampled, the most recent supervisions had been carried out in November 2018 and these had been mainly delivered by a clinical lead in certain specific areas of practice such as completing bowel care charts.

●Staff we spoke with who had been recently started at the service told us that they had not received the expected number of formal supervision meetings over their probation and induction period and although they had been at the service for over six months they still needed to complete their induction training.

● The failure to ensure all staff had received appropriate support, training and personal development and evidence that the service had assured themselves of their competence to carry out the duties they are employed to perform is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We discussed this with the manager. They told us that it was a challenge arranging training for staff with the current high levels of vacancies. We were told outstanding training was being arranged for the coming months. The manager also told us that their workload had meant they had not had time to carry out inductions and supervisions. There had been turnover of deputy manager and clinical lead positions since the last inspection which meant the manager had not had consistent support with their staff supervisory duties. The service had recently recruited interim staff into these positions and were recruiting permanently.

●The provider had recently invested in a new centralised training data base that allows oversight of where staff require training and will prompt when training is due to expire. This was designed to help avoid staff not receiving training in a timely manner. The provider had also made improvement to further support staff to complete training and keep their professional practice up to date by paying them for their time to attend courses and arranging access to IT equipment at the service or the nearby provider's central office to complete e-learning courses.

●Staff were offered on-going training in 'mandatory' subjects such as first aid, safeguarding, fire safety and manual handling. Training records showed an improvement in completion of 'mandatory' training courses, with nearly 100% of permanent staff having recently received these courses.

●There were arrangements to make sure that agency staff received training via their agencies in relevant sector specific training such as safeguarding and first aid with the expectation this was reviewed regularly. The manager told us that the provider was starting to make training available for agency staff in areas of practice specific to people's individual needs.

●The provider had recently changed their induction and probation policy to include the expectation that all new staff received relevant training and supervision that met Care Certificate Standards. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. It sets out learning outcomes, competencies and standards of care that care workers are nationally expected to achieve. The service was also committing to re-training staff in e-learning modules that correspond with the care certificate learning if their previous induction and training did not include these equivalents.

●The manager had recently started to issue documents offering staff advice on best practice. We saw one recent example of this, dated 11 January 2019 about advising staff how to record mental capacity decisions in a care plan. Other internal staff such as the Autism and PBS lead had also recently started to support staff by planning training workshops in areas of practice specific to individual needs, such as communication and Makaton. This was still in the very early stages of delivery but there were plans to continue these workshops and the sharing of information to help support staff to keep their knowledge up to date and in line with best practice professional practice.

Supporting people to live healthier lives, access healthcare services and support

● At the last focused inspection, we looked at specific areas of practice relating to people's healthcare support. We identified that systems to monitor people's health needs were not effective and people were at risk of not receiving appropriate or timely healthcare treatment. We also identified people's postural support needs were not being met. There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●At the focused inspection in August 2018 and at the last comprehensive inspection in June 2018 we had looked in more detail at all areas of people's healthcare support. We had identified that people's bowel care needs were not being safely met. We also identified that staff were not sharing information about people's health and treatment options between themselves and other healthcare services effectively. There was a breach of Regulation 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We have reported on how people's healthcare needs regarding monitoring their health and postural support were being met and if the breaches of regulations related to these areas of practice had been met in the 'Safe' section of this report.

●We looked to see if the provider had made necessary improvements and if the breaches of regulations had been met relating to other aspects of people's healthcare needs and found that they had.

●People told us that support with their healthcare needs had improved and they had support to access care and treatment. One person said, "I see them (the doctor) when I ask". Another person said, "The nurse helps me. I go to the hospital, they tell me when. They check my teeth with a dentist here."

●People were seen weekly by a visiting GP and nurses monitored people's daily health and well-being. People with bowel care support needs who were at risk of constipation had support to monitor this condition. This helped inform staff if they needed support to access further medicines or healthcare services if their needs changed and they stopped having bowel movements. People's bowel charts were being completed consistently and they were having support to make appropriate referrals or access medicines and treatment if necessary.

●People with specific healthcare conditions including epilepsy had received support to access relevant specialist services and make referrals for on-going advice and treatment. This information had been used to create support plans and about how best to meet their healthcare needs for staff to reference.

●People had 'Hospital Passports' in use that contained information about their health and communication needs. This was designed to be shared with healthcare staff to help maintain consistent support for people if they needed to go to hospital or use other medical services.

Supporting people to eat and drink enough to maintain a balanced diet

●At the last inspection we identified the management of choking and aspiration risks for people with more complex eating and drinking needs was unsafe and placing people at risk of harm. There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●We have reported on how aspiration and choking and other risks to people with complex eating and drinking needs are managed and if this breach of regulation was met in the 'Safe' section of this report.

● People told us they had enough to eat and were involved in decisions about what they eat and drink. One person said, "I choose in the morning from two things. They help me if I need it. I can ask." Another person said, "The food is okay. I choose and if I don't like something I can ask for something different. It is fine."

●There were monthly meetings between people and the chef where they could say what they would like to eat, including cultural or religious preferences and this information was used to plan menus in advance. Menus included varied choices and were changed regularly. Staff helped promote a balanced diet that met people's nutritional needs when discussing people's menu preferences.

●People and their relatives told us they had enough to drink. One relative said, "They have plenty to drink now, it often wasn't the case but recently they have been offering her a sip of water, tea and other things regularly".

● Where people were at risk of dehydration a recommended daily allowance (RDA) of fluids had been advised by a doctor. For these people, staff recorded how much they had been supported to drink on daily charts that referenced their RDA to monitor and manage this risk. Fluid charts showed these people had consistently been receiving their RDAs.

●Meals were appropriately spaced and mealtimes could be flexible to meet people's needs. People could eat in their rooms or in a communal dining room if they chose. To allow people to avoid excessive distractions and enjoy a calm environment when eating, there was a policy to limit movement and unnecessary noise in communal dining areas at meal times. We saw that people were not rushed when being supported with their meals.

Staff working with other agencies to provide consistent, effective, timely care

● At the last inspection we identified the service was not always working effectively in partnership with other agencies. There was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●We have reported more on our findings regarding how the service works in partnership with other agencies

at staff, management and senior organisational level, in the 'Safe' and 'Well-Led' sections of this report.

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

● The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We last inspected this area of practice at a comprehensive inspection in June 2018. We identified the service was not ensuring that people and those acting lawfully on their behalf had given consent before being provided with support. There was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●At this inspection we checked to see if the provider had made necessary improvements to meet this breach of regulations and found that they had.

●We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

●Staff had received MCA training and understood the consent and decision-making requirements of this legislation and could explain how they put these into practice when supporting people.

●In people's care files that we sampled, where people might lack mental capacity to be able to make decisions about different activities, this had been assessed and the outcome clearly recorded. Where they were not able to make certain decisions, the person with authority to act in their best interests in this area had been identified and involved in making any decisions about their care.

● Where people might require a DoLS there was a record of an appropriate assessment process and staff had submitted applications for DoLS for people. Where these had been authorised, relevant DoLS conditions were clearly identified and were being met.

Adapting service, design, decoration to meet people's needs

● The premises 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 place to another.

●The manager told us that they had recently made efforts to help ensure the service felt more like a home. A reception area had been re-designed, with noticeboards and tables and stands containing brochures removed and replaced with paintings, soft furnishings and plants. There were plans to remove the reception desk altogether from the entrance area.

●There were large communal areas where people could spend time with each other or with visitors. Several

of the communal areas had been recently re-decorated, with walls painted in colours that people had chosen and pictures and photographs of things people liked.

●People had their own bathrooms with en-suite facilities if they wanted to spend time alone. People's bedrooms had been personalised with their own pictures, decorations and furnishings.

●The service had an on-site sensory room and IT area where people could access computers. There was an on-site gym, but this was not in use. The manager told us there were plans to use the space as a social club to host events and provide a meeting place for people and their friends.

●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 was set in large private grounds that it shared with other services owned by the provider on the same site. There were wide paved pathways and people could access these grounds freely.

●The service had limited self-contained outside space, consisting of mainly paved areas. People had recently been supported to purchase new combined wooden trellis and flowerbed arches to be placed in these spaces, so people could do some gardening and to make using the outside space more pleasurable.

Requires Improvement

Is the service caring?

Our findings

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

●People did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

●We last inspected to see if the service was Caring during a comprehensive inspection in June 2018. We identified that people's privacy and dignity was not always respected. There was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●At this inspection we checked to see if the provider had made improvements and if this breach of regulations had been met.

● Some people said that staff did not always understand and respect their privacy and dignity needs when supporting them with intimate personal care. A complaint about a staff member's disrespectful conduct when supporting one person with their continence support had been recently upheld. Another person told us that staff had been, "rough" and spoken to them in a disrespectful manner when supporting them with intimate personal care. This had caused both people emotional distress.

● Staff were not always supporting people to be as independent as they wanted. For example, one person needed support to access a certain food but had recently expressed their wish to eat this independently. Staff were not respecting this and were continuing to feed the person this food rather than letting them do this for themselves.

●We observed another person asking for support to access the telephone so they could speak to their mother several times but was made to wait. There was no apparent reason for the refusal and why staff were not promoting this person's independence. The person was not offered an explanation as to why they were not being supported to be able to make the call when they wanted.

The failure to ensure all people were treated with dignity and respect is a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Staff made sure that if people wanted to only be supported by female or male staff when having personal care, this was arranged.

●Most people we spoke with told us they felt they could be independent. One person said, "I can go where I want (in the service)". We observed some positive examples of staff encouraging people to perform tasks that they were able. For example, one person needed support to be reminded to concentrate on being able to perform a task as independently as possible. We saw staff using appropriate touch to gently stroke the

top of the person's arm each time they lost focus and looked away. The gentle touching of their arm resulted in the person turning their head back towards the staff member and the task they were being supported with. The staff member was observed to be patient and spoke with the person in a soft and calm manner throughout.

●People told us that staff respected their privacy. One person said, "They knock on my door." Another person said, "I can lock my door but I don't need to". A person's relative said, "I get privacy when I visit and (their family member) gets it too".

●People told us they thought staff respected their confidentiality. There were data protection and record keeping polices in place to make sure that people's personal information was correctly stored, used and shared.

Ensuring people are well treated and supported; respecting equality and diversity

●We received mixed feedback from people about how well staff took their preferences and needs into account, including those related to their protected and other characteristics under the Equality Act 2010.

●One person said, "I get church services. I can pray and I feel they (staff) respect this." Another person said, "I like to be called a different name and some of them do that. It makes me happy. I would like them all to do that."

●A person's relative we spoke with said that although they did not have concerns regarding permanent staff's knowledge and respect of people's preferences and needs, they were aware that there was a high use of agency staff. They felt that could have an impact as agency staff, "Don't always have the knowledge (of people's needs) when they come in. Permanent staff were used to residents so there is a lack of continuity".

● Permanent staff members we spoke with understood the importance of respecting people's individual preferences and valuing diversity. One staff said, "You must support people with the life they want".

● Staff looked for accessible ways to help people communicate. We saw staff using Makaton to talk to and listen to people. Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order.

●The Autism and PBS lead had recently arranged communication training, including Makaton for all staff at the service to help reduce and remove barriers to staff and people understanding each other. A person using the service had been involved in facilitating the training session. Staff said having the person's input had been very useful in promoting an empathetic approach within the staff team about the way they communicated with people.

Supporting people to express their views and be involved in making decisions about their care

●At a comprehensive inspection in June 2018 we identified that people were at not always being included in making choices and were at risk that their decisions might not always be respected. There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●At this inspection we checked to see if the provider had made improvements and if this breach of

regulations had been met.

●We observed some positive examples of staff asking permission, answering questions and offering explanations when supporting people and talking to them about their care in a patient and personal way.

●However, we received mixed feedback from people about whether staff had time to listen to them and provide questions and information about their care. One person said, "They chat with me and listen to me...They help me do the things I like. I can choose". Another person said, "There are some staff, normally at night I don't know and they don't talk or ask me how I like things done for me."

●Some people said that they could talk to staff and they would respond and involve them in a personal way but staff were sometimes rushed. One person said, "Yes I can but I don't think they have much time to talk". Another person said, "Yes (staff have time to talk with me), some are quiet. Some busy".

●Relatives said involvement in care decisions was an area the service was improving in. One relative said, "Communication (about their relatives care and treatment) could be better. We did have a family's meeting with the provider last year that was useful for providing information about their care". Another relative said, "Staff seem to have more time to chat now and tell me a few more things and I can ask questions and get answers".

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

●We last inspected if the service was responsive during a comprehensive inspection in June 2018. We identified that people were not receiving personalised care that was responsive to their needs. There was a breach Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●At this inspection we looked to see if the provider had made necessary improvements and if this breach of regulations had been met.

●During the initial assessment process people or relevant people acting on their behalf had been involved. This had helped make sure that people's abilities and levels of independence regarding their physical health-related needs were documented and accounted for when planning their care and support.

●However, the initial assessment process did not include a balance of detailed information about people's non-physical health related support needs. There was limited documentation regarding people's personal history, individual likes and dislikes, interests and how these informed their support needs and choices. This was reflected in people's care plans, which contained only basic information about their wider mental, emotional and social needs and aspirations. Staff told us, "Care plans are not up to the standard that I expect". People told us they thought permanent staff knew them well. However, there was risk that agency or newly recruited staff would not have access to important information about people's support needs.

●Care planning processes did not always consider people's abilities and levels of independence in non-health related areas of their lives or their individual support needs and wishes in these areas of their lives. People did not always agree, review or develop their individual support planning and delivery to ensure that they were being supported to achieve their aspirations, build on their strengths and have the best possible quality of life. This increased the risk that people's support was not always wholly personalised or responsive to their needs.

● For example, where people had been individually consulted when planning their individual care and support, people told us that this was done mainly by staff talking with them. However, the consultation was not formally recorded or scheduled for regular individual review meetings. This created a risk that staff would not know or understand how to support people.

● Staff had received additional communication training recently and people had care plans detailing how they preferred to communicate. However, individual care plans and support schedules that were in use were not always explained, made accessible or available in formats that all people could understand. A staff

member told us, "Care plans are not user friendly, not accessible, could be more personal and we should involve people more in planning their care".

●This meant people could not confirm that their individual needs and choices were understood by staff and they were not in as much control as possible of the planning and delivery of their support. One person said, "I see things on the noticeboards in the dining room. Sometimes they don't put anything on for me on the day." Another person said, "I wanted to go to the beach today. I didn't know there was a trip. I would like to go out more". We observed one person asking repeatedly to see their care plan but this request was refused by staff without an explanation.

●All people living at The Laurels required high levels of support to be able to follow their interests and take part in activities that were socially and culturally relevant to them, including in the wider community. We had identified this as an area of improvement during the June 2018 inspection.

●There were monthly formal 'Activity and Menu' support meetings. An activities co-ordinator took ideas about group and individual activities people wanted to take part in and then created a monthly activity schedule for all people living at The Laurels based on this information.

●This had led to a greater variety of activities being on offer both within the service and in the community. For example, some people had recently been supported to explore appropriate education opportunities and had been enrolled at a local community college after expressing an interest in doing so. Another person with a specific sporting interest was supported on a related outing. A person said, "I get to go out more now. I went to the shops and to the beach today. It was very nice". A relative said "They are doing more with them. Going into the grounds and walking. We are talking about trips to garden centres and parks. I am hopeful this will start to happen more".

●However, activity schedules remained mainly generic, offered similar activities weekly and monthly and were mainly focused on group recreational activities with other people and staff from the service. Activities people were supported with were infrequently linked to any individual support needs or developmental life goals and aspirations.

●People's feedback about whether they had support with activities that interested them was not regularly reviewed on an individual basis to see what was and was not working and respond accordingly. Lack of available transport, staffing and flexibility in rotas meant that people were not able to easily go out on an individual basis. This impacted on people as they could not always go out during the day or in the evenings. This also meant that people did not always have support to attended social events or meet people with similar interests from the wider community.

●For example, one person with high levels of 1:1 support, seven days a week had only been scheduled to leave the service once in February 2019 to go to the doctor's surgery. They had only had a further three trips out into the community scheduled for the rest of February and these were group trips to a park, a tea shop and a pub. In January 2019 the same person had been scheduled one trip out to go to a hospital appointment. They had been scheduled a further four group trips out that month which were visiting a park, a 'drive', to go bowling and to visit a sensory room. Another person was being scheduled a 'drive' as their only activity outside of the service for one week out of every month during their 1:1 support hours.

●The failure to do all that is reasonably practicable to make sure people receive person-centred care that is appropriate, meets their needs and reflects their personal preferences is a continued breach of Regulation 9

of the Health and Social Care Act 2008 (Regulated Activities) 2014.

●Staff were aware of the need to improve activities support for people living at The Laurels. There were plans to involve permanent staff more formally in supporting the activity co-ordinators to plan and schedule individual activities. To help overcome the issue with rotas being inflexible, staff were being offered overtime as a short-term solution to support people to go out in the evenings if they wanted.

●An 'Engagement manager' was also helping staff to look at how the service could offer more personalised activities. They had recently arranged for a private travel service to offer 6 hours a week worth of transport to people at the service. The provider was also now pooling vehicles and drivers from all their services in the area to help people to be able go out more regularly.

Improving care quality in response to complaints or concerns

● There was a complaints policy that outlined the service's commitment to ensuring that any people raising a concern should be expected to be able to this without discrimination or disadvantage. Information about raising concerns was available for people in a file located in the service.

●People and their relatives told us that they were aware of how to make a complaint and felt confident to do so. However, both people and relatives told us that complaints had not always been handled effectively. This is an area requiring improvement.

●One person said they had not got the help and support they needed to make a complaint from staff, saying; "I complained but I don't think they listened to me. I tell other people like my family and they deal with things for me."

●Another person said they had raised a complaint about staff conduct and although they had received a response, they were not happy with the explanation of the outcome and were having to raise the complaint again.

●A relative told us responses to complaints had not always happened in a timely manner. They said, "I have complained to managers, nurses, staff in the past. Things have been done but really slowly". A person told us that this had been their experience too, saying; "They do sort things out. Slowly".

●The manager aimed to resolve complaints to people's satisfaction. They were aware where the person had requested a review of their complaint outcomes and would be following this up in line with the company policy.

●There was acknowledgement from staff that if there had been delays between receiving and responding to complaints in a timely manner, but that this was improving. One staff said, "We are reporting more". A relative said they could see concerns were being handled better recently, "Now when I have concerns the nurse or manager gets back to me quicker and I'm happier that things are getting done".

End of life care and support

● The service did not currently support anyone receiving end of life care. There was information available regarding the appropriate approach being supported with their end of life care regarding emergency resuscitation in the event of a medical emergency. There was an expected pathway for arranging any

necessary medical equipment and resources needed to support people approaching their end of life.

● The clinical lead told us that there was work underway to carry out an updated consultation and improve documentation regarding people's, or relevant people acting on their behalf, end of life support wishes. This would make sure that there was a more comprehensive resource for staff regarding how people wished to plan and make other decisions about their end of life care, including how their religious and spiritual wishes should be adhered to.

Inadequate

Is the service well-led?

Our findings

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

●There were widespread and significant shortfalls in service leadership.

●Leaders and the culture they created had not assured the delivery of high-quality care.

●Some regulations were not met.

Managers and staff being clear about their roles and understanding quality performance, risks and regulatory requirements, continuous learning and improving care and working in partnership with others

●At the last inspection we identified that the service was not well-led. There was a breach of breach of Regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (CQC) (Registration) Regulations 2009

●At this inspection we looked to see if the provider had made necessary improvements to meet these breaches of regulations.

●We found that there had been an improvement in submission of statutory notifications and the breach of Regulation 18 of the Care Quality Commission (CQC) (Registration) Regulations 2009 had been met but the service remained in breach of Regulation 17 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014.

●Quality assurance and governance systems were in use and there were internal and external quality support and clinical staff working with staff and management on-site on an on-going daily basis. However, these systems and support resources were not being used effectively to support staff and management at the service to understand their responsibilities, manage safety risks and deliver a good standard of person-centred care at the service.

●For example, there were several different internal and external audit processes in place specific to certain areas of service delivery such as medicines or record keeping, as well as more comprehensive audits looking at all areas of service performance including meeting of contractual and legal requirements. Where they had been carried out, each audit had varying actions identified for completion to address any issues or risks.

●However, management had not ensured that internal audits were always being carried out as expected by the staff responsible for doing so. Where they were carried out, issues and actions identified from individual audit processes were not always communicated between staff and management or added to a local or centralised development plan with designated timeframes and a person or people responsible for ensuring they were completed.

●This meant that staff and management at all levels of the organisation were not always aware of potential risks that might compromise safety, quality, or relevant legal requirements and had therefore not been able to always act on these. Where management were aware of issues and recommendations, they had not always ensured that actions to address these had been completed in a timely manner or at all.

●For example, the current overall service development plan showed many historical actions had overrun their expected timeframes for completion significantly and some continued to remain outstanding. Some actions remain marked as completed within the provider's expected timeframes although in other areas of the plan, actions had since been updated to show they are incomplete.

● The development plan showed actions that had been allocated a determined level of risk that did not reflect the provider was always aware of statutory or contractual requirements or had effectively evaluated the level of risk to service users. There were significant gaps where no actions had been added to the development plan although many internal and external audits had taken place at the service during these periods. Review of individual audits showed actions not assigned timeframes or people responsible for making sure issues were addressed and also showed incomplete actions.

●Other issues identified during this inspection regarding preventing and learning from safety incidents, failing to mitigate risks to service users, monitor and manage people's healthcare needs, high staff turnover, lack of adequate support and supervision for staff, failure to deliver person-centred care and dignified support and operate effective quality assurance systems and governance frameworks have been identified as inadequate or requiring improvement in some or all of six consecutive CQC inspections at The Laurels since May 2017.

●Since the last comprehensive inspection in June 2018, the service had continued to be in breach of Regulations, 9, 10, 12 ,17 and 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014.

●The lack of clarity and shared understanding between staff and management regarding quality and safety risks impacted on direct support staff, who did not have clear and transparent processes to account for their decisions, actions behaviours and performance. This lack of understanding also affected the overall ability of the service to effectively work in partnership with others and learn, improve and develop.

●For example, since the last inspection in October 2018, five people had moved out of the service. We discussed this with the manager who told us, "Staff did not have the skills and competencies to meet people's needs so they moved on". When asked what had contributed to this situation they told us, "There was a lack of delegation of tasks among the staff teams so things were not getting done. There was poor communication". Staff told us, "We need to know what happens on both units. The communication is better than it was. It's not perfect".

●This view was shared by other agencies and stakeholders who worked or were involved with supporting people and staff at The Laurels.

●For example, an external pharmacist audit in February 2019 noted that medicine errors that were occurring were all avoidable and that there was a lack of responsibility and ownership at management level in ensuring actions had been completed to mitigate the risk of these occurring. The audit also recommended that, "clinical leaders, including RGNs should understand the importance of learning from incidents as well as investigating them."

●An external healthcare professional gave an example of how recommendations they had made regarding people's support plans and guidelines had not been consistently followed. This had been due to issues with external and internal communication and lack of staff and management understanding of their respective responsibilities.

●After working with the service for a period, the healthcare professional felt this situation had been the result of, "Multiple issues relating to the service model and organisation at a management level…it is unclear how the relationships and lines of accountability work between all the different people. I mainly liaise with the support staff and staff nurses as they know the clients best, but they do not necessarily have the systemic level of influence required to make guidelines consistently followed".

●Some relatives told us that staff and management lacked a shared understanding of key challenges, concerns and risks. One relative said, "There is a fear in staff, they are not sure what they have done wrong. Management are having a big push to try and understand all that is necessary to let staff know what they need to do".

● 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.

●The service had recently invested in a new IT system that incorporated email communication for all levels of staff and accessible centralised information systems for management to share and store service data.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility,

●The provider had recently rebranded their organisation and identified the provision of person centred care as their new vision. The manager acknowledged that realising this vision would require a significant cultural change within the service and the organisation. Although quality assurance and governance frameworks, including direct management and communication systems such as formal supervisions, meetings and information sharing, were not operating effectively the manager remained committed wherever possible by taking informal opportunities such as talking with staff on shift about their performance. The manager had an open-door policy as a platform to promote a culture that valued staff working together in an open and honest way to deliver quality person-centred care.

●Staff said the changing approach from management was helping promote a more honest and open environment and encourage people to work together to achieve good outcomes for people. One staff said "I thought I was not coming back here…With change – it's not an accepted thing. When I first came, the morale was low. There was no open door, but the door is open now… We all need to be involved and need to remind each other. The manager is more open and more accepting now. They will walk around and they communicate with us. The culture is slowly building – the team work. There's still a lot that can still be improved".

●Relatives told us they felt the service and the provider had been more committed to providing better quality care and were starting to act more openly over the last few months. One relative said, "The service and the provider are not so good in terms of communicating about what has gone wrong. They are upping

their game recently". Another relative said, "They are more available now to talk to. Changes are happening slowly".

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

●People told us that they knew who the manager was and could talk to them. The service had recently started exclusive meetings just for people living at The Laurels to enable them to have more regular opportunity to share their views and experiences of using the services. The Autism and PBS lead told us that having people lead their own meetings was a necessary step towards encouraging and improving accessible communication with all people who use the service. They told us they had found that previous staff led meetings had proved disempowering as staff had not always respected people as equal adults and had spoken for them.

●The Autism and PBS lead said there was, "still a lot of learning for staff" about respecting people's equality characteristics but that they were supporting them by positively challenging staff when this disrespect happened. They gave an example of how they had recently asked staff to leave a service users' meeting as they were speaking for people without their consent.

● These changes in allowing service users to be more actively involved in developing the service had resulted in some outcomes and these were displayed via written messages on noticeboards in the service saying where how the feedback had been acted on to date. The Autism and PBS lead was hopeful that they would continue to gather meaningful information to develop the service in future and offer more opportunities for doing this and sharing outcomes in accessible ways for people.

●Relatives said they had recently had more opportunities to be able to give feedback about how the service was performing via some meetings that had been organised by the provider. On relative said, "Only last year we had a families' meeting. I felt they acknowledged what we said."

●Staff said there were more regular team meetings and this gave staff an opportunity to have some input about how to improve the service. Staff said that since the last inspection there also been an improvement in the management response to staff feedback. One staff said, "There are staff meetings once per month at daily handovers – everyone is present. We have daily meetings at 11.00am. They are happening. We talk about today, tomorrow, if someone is sick, trips out, what we need…I've never had a problem talking to the manager".

●The manager told us about a planned revision to current staffing structures and job roles for direct support staff to create a singular 'Support Worker' role. This role would have more comprehensive and direct responsibilities to support people in line with the recently created key organisational value of person-centred care.

●Although there was no set date for this change to take place, it was hoped that once made, this would empower staff to have more input into suggesting and managing improvements and developments at the service, including new ways of working to make sure that this value was put into practice effectively.

●The provider had recently changed their recruitment policy to make sure that all staff's involvement and engagement with all employees at all levels within the service and the wider organisation would be encouraged and valued equally, regardless of any protected characteristics under the Equality Act 2010.

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 assess and design care and treatment with a view to achieving service user's preferences and ensuring their needs are met. Failure to do all that is reasonably practicable to make sure people receive person-centred care that is appropriate, meets their needs and reflects their personal preferences

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 The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users, ensure safe and proper use of medicines and thoroughly review, investigate, monitor and make sure remedial actions and improvements are made in relation to incidents that affect the health safety and welfare of service users or have adequate arrangements to respond appropriately to people's changing healthcare needs.

The enforcement action we took:

We imposed conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were 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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not done all that is reasonably practical to assess and mitigate risks and provide safe care and treatment to service users, ensure safe and proper use of medicines and thoroughly review, investigate, monitor and make sure remedial actions and improvements are made in relation to incidents that affect the health safety and welfare of service users or have adequate arrangements to respond appropriately to people's changing healthcare needs.

The enforcement action we took:

We imposed conditions on the providers registration.