Defiant Enterprises Limited

The Laurels Care Home

Inspection report

The Laurels
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 23 May 2016. After that inspection we received concerns in relation to how the risks associated with people not eating and drinking and developing a pressure ulcer were being managed. As a result we undertook a focused inspection on 28 September 2016 to look into those concerns. This focused inspection was also unannounced. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk"

The Laurels Care Home is a care home that provides accommodation and personal care for up to 52 people. The provider's website describes the service as one that 'specialises in round the clock dementia care and care for frail people.' At the time of our visit, there were 45 people living in the home, the majority of whom were living with dementia.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Risks to people's safety had not always been assessed. Where they had been, adequate actions had not always been taken to keep people safe.

Not all people living within the home had received adequate support to ensure they received enough to eat and drink to meet their individual needs. This had resulted in some people losing a significant amount of weight.

There were a lack of effective systems in place to assess and monitor the quality of care provided to people. The provider had not followed their own policies in respect of how to meet people's eating, drinking and pressure care needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks to people's safety had not always been assessed. Actions required to protect people from the risk of harm had not always been taken.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all people received enough to eat and drink at all times to meet their individual needs.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The current systems in place to monitor the quality and safety of the care provided were not all effective.

The Laurels Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of The Laurels Care Home on 28 September 2016. This inspection was completed in response to concerns we had received about the care being provided within the home. We inspected the service against three questions we ask about services; is the service safe, is it effective and is it well led.

The inspection was undertaken by one inspector and a specialist advisor in dementia care.

Before the inspection we reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us and additional information we had requested from the local authority safeguarding and quality assurance teams.

The people whose care we looked at in detail were not able to provide us with detailed feedback about the care they received at The Laurels Care Home. We therefore spent time observing the care people received. This included general observation and by using the Short Observational Framework for Inspection (SOFI) to observe the care and support provided to people within a communal area of the home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection visit, we spoke with five care staff, the cook, the head of care and the registered manager.

We looked at the care records of eleven people who had received care at the home and records in relation to how the provider monitors the quality of care provided.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection, we had received concerns that the provider was not taking sufficient action to reduce the risk of people developing a pressure ulcer. During this inspection, we found this to be the case. We also found that other risks in respect of people's safety had either not been assessed or sufficient actions had not always been taken to protect them from the risk of avoidable harm.

During the initial assessment of three people's needs before they moved into the home, the registered manager had identified that they had a history of falling. After they had moved into the home, we found that two of these people had experienced a fall. One in June 2016 and the other in July 2016. Both of these incidents had been reported and investigated and neither had fallen since. However, their risk in relation to falls had not been assessed and there were no care plans in place to guide staff on how to reduce this risk. Some of the staff we spoke with were not aware that these two people had a history of falling and therefore, were not clear what action they needed to take to keep them safe.

We observed that one person who was lying on their bed had a crash mat underneath it. A staff member told us the mat was used to reduce the risk of the person experiencing an injury should they fall out of bed. We asked the staff member why the mat was under the person's bed rather than next to it. They told us this was because they were just about to assist the person to eat their evening meal. We saw that the person's evening meal was in their room in preparation for this. The staff member said they had placed the crash mat under the bed so they could sit next to the person and give them assistance with their meal. However, the staff member was not in the room with the person when we initially observed the crash mat out of place and we saw them leave the person for three minutes whilst they spoke to another staff member. This meant the person was at risk of injury if they had fallen out of bed when the staff member was not present.

Risks in relation to people developing a pressure ulcer had been inconsistently assessed. Some people's risk had been regularly assessed and reviewed. Others had been assessed but not regularly reviewed whilst some people's risk had not been assessed at all. For those people whose risk had been assessed, the actions required to be taken by the staff to mitigate the risk were not always clear. Where actions had been identified, these had not always been followed to prevent the risk of harm.

Two of the people whose care we looked at had developed a pressure ulcer. One person had been admitted to the home in June 2016 for respite care. Before they moved into the home, the registered manager had conducted an initial assessment of their overall needs. They had identified that the person was at risk of developing a pressure ulcer and that therefore, a more thorough assessment of this risk needed to be completed when the person moved into the home. They had also identified that to help reduce this risk, the person needed to be re-positioned by the staff every three to four hours. However, a more comprehensive risk assessment did not take place.

The records we saw showed that the person had not been re-positioned regularly until two weeks after they had moved into the home. This was after the person had been seen by a visiting healthcare professional who found the person had severe redness to an area of their body. A subsequent investigation completed by

a healthcare professional, concluded that the mattress the person used when they were in the home had been a contributing factor to them developing a serious pressure ulcer. This was because the person had been using a specialist mattress in their own home which had not been replicated when they had moved into The Laurels Care Home.

The other person who had a pressure ulcer was using a specialist pressure mattress when in bed. A member of staff told us the person was required to be re-positioned every two hours. However, at 12.20pm on the day of the inspection, it had been recorded that they had last been re-positioned at 6am that morning. This meant that there was a risk that they had not been re-positioned for over five hours.

Five other people who had been assessed as being at high risk of developing a pressure ulcer were not receiving all the required interventions to reduce this risk. The staff told us that the registered manager's instructions were to re-position people every two to three hours but this had not been achieved. For one person, it had been recorded they had not been repositioned on the 24 September for a period of four hours on one occasion and another for six hours. For another person, they had not been re-positioned on 25 September 2016 for over five hours and a further person on 26 September 2016 for six hours.

We received mixed views from staff as to whether they had time to re-position people in line with the registered manager's instructions and therefore, whether the records of re-positioning were correct. Some staff said they could do this but others said they did not always have time, particularly if they were short of staff due to unplanned staff absence. The registered manager told us that staff had received training on how to meet people's pressure care and skin integrity needs. However, none of the staff we spoke with could recall having received this training. We saw some evidence that staff newly employed to the home, received some training on the subject during the completion of their induction training.

During our observations around the home, we found that two people's rooms contained a tin of 'thick and easy' (for thickening drinks) powder that was not secure. The doors to these people's rooms were unlocked and therefore, other people living in the home could enter their room freely. There was a risk that some people could ingest this powder if they did not understand what it was. This could cause them harm.

A staff member told us that one person who was in their room had an infection. They said because of this, staff were required to take extra precautions to reduce the risk of the spread of this infection. However, there were no signs or indications outside the person's door that this was the case. One staff member we spoke with was not aware that extra precautions were required when providing this person with care. Therefore, there was a risk of the spread of infection within the home. We spoke with a senior member of staff about this. They immediately placed a sign on the person's door. This directed staff and visitors to wear protective clothing before entering the room and to wash their hands after visiting the room.

The above evidence demonstrates a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Requires Improvement

Is the service effective?

Our findings

Prior to the inspection, we had received concerns that people were at risk of dehydration as they were not receiving enough to drink. During this inspection, we found that people had not received enough to eat and drink to meet their individual needs. Sufficient action had not always been taken to make sure some people maintained a healthy weight.

Seven of the eleven people whose care we looked at had lost weight either since January 2016 or from when they had started to live in the home. We were able to determine that the percentage of weight loss experienced by these people ranged between five and twenty-two percent. For three of these people, their weight loss had been significant.

One person had lost 22% of their bodyweight since February 2016. Their risk of not eating enough had been assessed each month since that date. However, this risk had been assessed incorrectly, identifying them in May 2016 as low risk when in fact they were at high risk. Some action had been taken in an attempt to increase this person's weight such as giving them food fortified with extra calories. The cook we spoke with confirmed this. However, no other actions were being taken to help this person increase their weight. The person had not been seen by a healthcare professional who would have been able to offer the home specialist advice regarding the matter. We saw this person receive the assistance they required to eat their lunch time meal within a communal area. They finished their meal but were not offered a second portion.

Another person had lost 19% of their bodyweight between January and August 2016. Again, their risk of not eating enough had not been assessed correctly. Due to their low body weight, their risk in January 2016 was high but they did not see a specialist healthcare professional about their weight loss until June 2016. Some actions had been taken by the staff to increase their calorific intake but this had not been consistently applied. The person was having their food fortified but the records indicated that they did not always receive their high calorie drinks as prescribed by the dietician. We noted that since the person had seen the dietician they had lost a further 13% of their bodyweight. The registered manager told us that this person could often eat independently. However, we did not see that they were left with snacks they could help themselves to throughout the day.

The third person had lost 11% of their bodyweight since January 2016. They were receiving food fortified with extra calories but when asked, the registered manager was unable to advise whether they had seen a specialist about their weight loss. They were unable to confirm if any other actions were being taken to increase this person's nutritional intake.

The registered manager had assessed that some people who were at risk of not eating enough needed to be weighed weekly. This was so they could monitor whether the action they were taking to increase their nutritional intake was effective. However, we saw that this had not occurred. These people had last been weighed in the first week of September 2016 and therefore not for the two weeks prior to our inspection.

At the beginning of the inspection, the registered manager told us that people who were at risk of not eating

enough had their food intake recorded each day. We asked for copies of these records twice during the inspection visit but they were not supplied to us. After the inspection visit we again requested copies of these records but were told by the registered manager that all available records had been given to us during the day of the inspection. Due to the absence of these records we were unable to establish whether people were being offered snacks regularly between meals to bolster their food intake. For one person, we saw that the GP had requested the staff take action to ensure the person had a 'good nutritional status'. However, the registered manager told us they were not monitoring this person's food intake. Therefore there was no robust mechanism in place to enable them to make sure the GP's instructions were being followed.

During our observations, we saw one person refuse their lunch as they said they felt unwell. The registered manager told us that such concerns relating to people not eating or drinking enough were discussed in daily handover meetings. These meetings took place each time the staff changed shift. We observed the handover meeting and saw that this information was not communicated to the new staff who were coming on shift. The morning staff told the afternoon staff that there had been no issues with the person's care and that they were 'fine'. Therefore, there was a risk that staff would not encourage this person to eat food in the afternoon to meet their needs.

The registered manager told us that each person who had been assessed as being at risk of not drinking enough had a fluid target to reach each day. They said this target was calculated for each individual person and was based on best practice guidance provided by the NHS. However, we saw that six of the seven people whose care we looked at in respect of hydration, all had the same target of 800ml to 1000mls per day. As this target had not been calculated based on people's individual needs, there was a risk that some people may not have received enough drink.

The registered manager told us that staff offered people who were at risk of not drinking a drink every two hours. In most cases, the records we saw showed that people had been offered a drink at this frequency. They also showed that on occasions, when the person had not reached their target fluid intake for the day, the frequency of offering drinks the following day had increased to each hour. However, this had been inconsistently applied and access to drinks had not always been increased when there was a need. We also saw that people rarely exceeded the daily target set for them and that once people had reached this target, the staff went back to offering them drinks every two hours. This action sometimes resulted in a reduced amount of drink being consumed on the subsequent day.

A healthcare professional we spoke with told us they had asked the staff to monitor one person's fluid intake in August 2016 as they were concerned the person was dehydrated. However, this instruction had not been followed. We checked this person's care record and found that a healthcare professional had requested the person have more fluids but there were no records to confirm this had occurred.

We saw that some people who were in their rooms could access a drink when they wanted to. However, two people that we were told by staff were at risk of not drinking enough did not have drinks within their reach. One person when asked, told us they were thirsty. We alerted a member of staff to this who promptly handed them a glass of juice, some of which they drank. We asked the registered manager why the drink had not been within the person's reach if they could give themselves a drink. They told us that they did not know but thought it might be because the person would kick the table. When we returned 25 minutes later we found the drink again, out of the person's reach. The registered manager confirmed to us that the other person could also assist themselves with a drink. They could not provide an explanation as to why the drink was not in the person's reach so they could help themselves if they felt thirsty.

The staff told us that a tea trolley came around to serve hot and milky drinks to people four times during the

day. However, during the interim periods people did not have drinks by them that they could freely access to encourage their fluid intake. We advised the registered manager of this in the afternoon. They told us that people should have drinks by them at all times and was unable to explain why this had not been the case. They then provided people with drinks. We also saw in the morning, one person request a cup of tea before the tea trolley had appeared. They were told by a member of staff that the 'tea trolley would be around soon'. After 15 minutes the person again requested a cup of tea. They were becoming distressed and upset as this request had not been responded to. The staff member then got them a cup of tea. The tea trolley arrived 65 minutes after the person had requested the cup of tea.

One concern raised with us prior to the inspection was that people who were approaching the end of their life had been found dehydrated when visited. Two of the people whose care we looked at were approaching the end of their life. One person's fluid intake was not being recorded and therefore could not be monitored by the registered manager to make sure it was sufficient for the person's needs. Another person's fluid was being recorded. However, we saw that their fluid intake target had recently been reduced. We spoke to a healthcare professional about this who told us this was not appropriate and that the person, due to an infection they had, should have their fluid intake increased. They agreed to speak to the registered manager about this.

All but one person who had been identified as being at risk of not eating or drinking had a care plan in place in relation to this. The information within these care plans to guide staff on what actions to take to ensure people received enough to eat and drink was however, variable. Some contained specific actions for staff to take to decrease the risk but others contained no guidance about how often staff were to offer people food and drink, the types of food and drink people liked and how they could encourage people's intake. Two other people who lived in the home did not have any care plans in place in relation to their individual eating and drinking needs.

We received mixed feedback from the staff about whether they were able to provide people with sufficient encouragement to eat and drink enough to meet their individual needs. Some staff said this was not a problem but others told us that they did not always have time to do this and that people did not always get offered regular snacks and drinks to help them put on weight or to avoid dehydration. The registered manager told us that staff had received training in relation to meeting people nutritional and hydration needs. However, none of the staff we spoke with could recall having received this. We saw some evidence that staff newly employed to the home, received some training on the subject during the completion of their induction training.

The evidence above demonstrates a breach or Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We observed that people were offered a choice of meal at lunchtime and that the meals looked appetising. Some people were seen requesting options that were not on the menu and these requests were met. We saw that people in the communal areas of the home were offered snacks such as cakes or cheesecake when the tea trolley was brought around. Where people had specific dietary requirements, this was being met. For example, where people required a soft diet they received this. Where people required assistance to eat their meal, we saw this was given.

Requires Improvement

Is the service well-led?

Our findings

The systems in place to assess and monitor the quality and safety of the care provided were not effective.

The registered manager told us they monitored daily that actions had been taken to reduce the risks of people not eating and drinking enough and of them developing a pressure ulcer. They said this included observation around the home and the review of people's food, fluid and re-positioning records. However, we found that this was not effective as we identified serious concerns in these areas.

We also found that the records the registered manager was checking to assure themselves that people were receiving enough to drink may not have been an accurate reflection of the care people had received. This was because on the day of the inspection, some of these records had not been completed by the staff member who had provided the care. A senior member of staff was observed to be completing a number of these records at 3pm on the day of inspection. When asked, they told us they had received feedback from the staff of when people had received food, drink and re-positioning and were completing the records on their behalf. They told us this was common practice.

No audits were in place to assess whether people who were of low weight had been referred to the relevant healthcare professional or that they were receiving adequate food and fluids. There was no system in place to make sure people who were required to be weighed regularly received this or that risks in relation to people's nutritional, hydration and pressure care needs had been regularly assessed and calculated correctly.

A number of people's care records were incomplete. This issue had been identified during our inspection in May 2016. During that inspection we were told by the provider that all care records would be reviewed and completed by June 2016. However, we still found that some people's care needs or risks to their safety had not been fully assessed. Therefore sufficient action had not been taken to ensure that staff had relevant guidance in place to understand what care they needed to provide to meet people's needs.

The provider's own governance systems had not identified that they were not following their own policies and procedures in relation to meeting people's eating, drinking and pressure care needs.

The provider's policy entitled, 'Nutritional and hydration needs' states that each person who is malnourished or at risk of malnutrition should have a care plan in place that aims to meet their nutritional requirements. It also says that people who are screened for risk should have their nutrition support goals documented. We found that this action had not always been taken.

The provider's policy entitled, 'Pressure sore risk assessment (PSRA)' states that in relation to the risk of people developing pressure ulcers that, 'The initial calculation and score should be ascertained, if possible, either before commencement of the service or within 24 hours.' Again we found that this had not always happened.

The provider's falls policy entitled 'Falls prevention' states that 'if the care or support needs assessment identifies that the individual is at risk of falling, a falls risk assessment will be carried out immediately prior to or when the service commences.' It also states that, 'if there are any changes in the resident's health or they begin to fall, a falls risk assessment will then be carried out.' This had not been consistently applied.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. Risks to service users had not always been assessed. Where they had been, actions had not always been taken to mitigate these risks. Regulation 12, 1, 2 (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs were not being met for all service users to sustain good health. Regulation 14, 1, 2 and 4 (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess, monitor and improve the quality and safety of the service provided and to assess, monitor and mitigate risks relating to the health, safety and welfare of service users were not effective. An accurate and complete contemporaneous record in response of each service user was not in place. Regulation 17 1, 2 (a), (b), (c) and (f).