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The Laurels

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

The Laurels is a residential care home registered to provide care and support to up to 20 people. The building had been adapted and care was provided over two floors with stairs and a stair lift as access. There were 13 people living at the home at the time of inspection.

People's experience of using this service and what we found

Improvements were needed to the governance within the service. Systems were either not established or effective in identifying the shortfalls found within this inspection. Statutory notifications had not been submitted to CQC as required to ensure we are informed of events that happen with services.

Safety checks were not always carried out as planned to ensure people were living in a safe environment. We raised this immediately with the provider who sought to rectify the shortfall by arranging external professionals and trades people to carry out the checks. Risk assessments were not always in place to ensure people were safe from avoidable harm. Reviews did not take place as planned. We have made a recommendation about risk management within the service.

Accidents and incidents were recorded, and the necessary actions taken. However, analysis was not robust to ensure lessons were learned to prevent reoccurrence of incidents. This meant people could be at increased risk. The Laurels did not actively seek formal feedback from people, their relatives, staff and professionals in order to drive continuous improvements.

We have made a recommendation about recruitment processes; they had not always been followed which meant staff did not always have the necessary checks to ensure they were safe to work with people who required care and support.

People received their medicines as prescribed. However, some improvements were needed to guidance for staff where medicines were taken occasionally and storage arrangements.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Safeguarding procedures were in place and staff knew them well and were confident the provider would take any concerns seriously. Infection control procedures were robust and in line with the latest government guidance for best practice.

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

Rating at last inspection

The last rating for this service was good (published 3 March 2022).

Why we inspected

We received concerns in relation to the management of the home. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for, The Laurels on our website at www.cqc.org.uk.

Enforcement and Recommendations

We have identified breaches in relation to the management oversight in the home and failure to notify CQC of events as required by law at this inspection. We have made a recommendation about the providers recruitment process and risk management within the home.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was carried out by one inspector.

Service and service type

The Laurels is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Laurels is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority service improvement and safeguarding teams. The provider completed a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with three people who used the service about their experience of the care provided. We spoke with four members of staff including the provider and care workers. We made observations throughout the day of interactions between people and staff.

We reviewed a range of records. This included six people's care records and medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People did not always have risk assessments for all their care and support. Some were personalised to the individual and others not as detailed. Some risk had not been identified by the provider. They told us they were in the process of changing risk assessments to be in the same format.
- Risk assessments were not always up to date. The providers policy of monthly review had not always been followed.
- Risks within the environment had either not always been identified, checked or robustly assessed. Gas safety, electrical safety has not been established within the home. Annual electrical equipment checks had not been carried out. Fire checks had been completed. However, a fire risk assessment had not been carried out. We raised this with the provider, and they arranged appointments for all checks which were out of date.

We recommend the provider seeks guidance from a reputable source to ensure robust risk management within the service.

- Accidents and incidents were recorded. However, analysis and review of incidents had not taken place as planned. This meant that patterns had not been recognised for a people and could have increased their risk of harm, for example, where they had falls. The provider told us they would ensure the analysis was updated and completed monthly as they had planned.
- Staff knew people's risks well. They told us how they would support people safely in different ways, for example, with their mobility and movement.

Staffing and recruitment

- Recruitment processes were not always followed. Staff did not always have the necessary checks in place before they started work, for example, two staff files did not contain the two references required by the providers policy. The provider told us they would ensure the files were up to date and complete.

We recommend the provider follows their procedure for the employment of all staff to ensure robust checks are made on the suitability of staff to work with people who require care and support.

- The employment process included employment history, references, health checks and Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- There were enough staff on duty. People told us there was enough staff around the home to support them when required. We observed the home to have a calm atmosphere, staff were not rushed.

Using medicines safely

- People received their medicines as prescribed. However, where medicines were taken occasionally, guidance for staff was not always personalised to ensure they were given consistently. The provider told us the shortfall would be addressed.
- Medicines that required stricter controls by law were recorded and a stock book was maintained accurately. Medicines were stored in a locked cabinet within a locked room. However, we found that the cabinet was not secured to the outer wall in line with legislation. The provider told us they would ensure this was addressed immediately.
- Medicines were stored securely, and storage temperature checks were maintained correctly.
- Medicine administration records (MAR) were in place for each person and these were completed accurately.

Systems and processes to safeguard people from the risk of abuse

- Staff received training in safeguarding people. They knew who to report concerns to both within the home and outside. Staff were confident their concerns would be listened to by the provider and acted upon.
- People and staff told us; The Laurels was a safe place to live. People told us they were happy, and the staff were kind and caring. Staff told us they thought people were safe because, they worked as a team to care for them, like family.
- There was a system in place for discussing safeguarding concerns. This was done within daily handovers which were recorded, staff told us they could catch up on concerns if they had been off work. The provider supported with care for people, staff told us they were able to speak to them each day.
- Referrals had been made to the local authority safeguarding team as required.

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

- We were assured that the provider's infection prevention and control policy was up to date.
- The Laurels were supporting visitors to the home.

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Quality assurance systems did not operate effectively. Audits and monitoring were not always in place and therefore had not identified the shortfalls found within the inspection. For example, risk assessments and the recruitment process.
- Oversight from the provider had not identified the shortfalls within the service. There was no formal audit or measurable system for checking the standard at which the home operated.
- Systems to drive continuous improvements in care were not in place at the home.

The provider had failed to ensure governance systems were operating effectively to ensure risks were managed, recruitment processes were safe, and the service improved. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection to re-establish the management of the home and delegate responsibilities within the team.

- The home did not have a registered manager in post and an application had not been made to the CQC. The provider told us they intended to make an application.
- The provider had not made statutory notifications to CQC as required by law. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. The provider had not submitted statutory notifications since March 2022. The provider told us there were four notifications they needed to submit, during the inspection we found a further two notifiable events that had not been submitted. We told the provider to submit the notifications to CQC retrospectively.

The provider had failed to inform CQC about events that occurred in their service as required by law. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

The provider responded immediately during and after the inspection. The provider submitted statutory notifications retrospectively and gave verbal assurance they would submit notifications as required.

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

- The provider understood the requirements of the duty of candour, that is, their responsibility to be honest, open and apologise for any accident or incident that had caused or placed a person at risk of harm.

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

- The provider did not seek formal feedback from people, their relatives and external professionals and use it to drive improvements within the home. The provider told us they were planning to issue surveys in January 2023.
- Meetings did not always take place within the home. The provider could not assure themselves they were listening to people's views and they were involved in their home.
- The home had not made links for people to be part of their local community.
- The home worked well with external health and social care professionals.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff told us they felt involved in the home and were listened to by the provider and management team.
- People and staff were positive about the management of the home. Some of the comments we received were: "You can always ask for help", "We can ask for support or even call the provider [name] and they always answer", "We are supported."
- Staff felt proud to work at The Laurels. Some of their comments were: "I feel proud to work here for my residents", "I love it here", "I am proud to work here, we are like a family and we all get along so well."

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 17 HSCA RA Regulations 2014 Good governance Governance systems were not operating effectively.