Laurel Lodge Care Home

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Inspection report

19 Ipswich Road
Norwich
Norfolk
NR2 2LN

Date of inspection visit:
17 March 2016

Date of publication:
26 April 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

Laurel Lodge is registered to provide accommodation and personal care for up to 27 older people. There were 25 people living at the home at the time of our inspection.

We carried out an unannounced inspection of this service on 17 March 2016 following concerns about how environmental risks are managed.

At the time of this inspection 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. The registered manager is also a director of the company who are registered as the provider of the service.

This report only covers our findings in relation to the key question of whether the service provided safe care. We previously carried out a comprehensive inspection on 11 June 2015 at which we rated the service. You can read the report from our comprehensive inspection of 11 June 2015, by selecting the 'all reports' link for 'Laurel Lodge Care Home' on our website at www.cqc.org.uk. We have not changed the rating for the key question of safe in this report and will return to carry out a comprehensive inspection at the home at which we will provide an updated rating.

We found during this inspection that the provider did not ensure that all reasonable steps were taken to ensure the risks to people were minimised. Risk assessment's were inadequate, did not consider the risks and did not provide clear guidance to staff about how to manage risks. Where risks had been identified the provider had not taken action to reduce the risks in a timely way.

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 safe

The environment was not safe. Improvements were needed to ensure any risk to people's safety and welfare were identified and acted on.

Risks to people's health and wellbeing were not consistently identified, managed and reviewed.

Action had not been taken in a timely way to reduce risks.

We have not changed the rating for this key question but will review at the next comprehensive inspection.

Laurel Lodge 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 a focused inspection of Laurel Lodge Care Home on 17 March 2016. This inspection was unannounced and was in response to concerns about how environmental risks were managed. We inspected the service against one of the five questions we ask about services: is the service safe.

This inspection was undertaken by two inspectors.

During our visit we spoke with the registered manager, the general manager and to one care staff. We also spoke to four people living at the home.

At the inspection we looked at two people's care plans, accident and incident records, risk assessments and staff team meeting minutes.

Requires Improvement

Is the service safe?

Our findings

We carried out this inspection to check if the premises used by the service provider were safe to use for their intended purpose and if they were being used in a safe way. We looked at how the provider managed risks so that people were protected. We found that risk assessments were not reviewed regularly and lacked detail. For example, the hot water risk assessment had not been reviewed since 2011 and did not contain adequate detail for an effective assessment to have been carried out of the risks. The risk assessments that we saw did not contain any reference to current guidance or legislation about how to manage risks regarding hot water, exposed hot water pipes and radiators We found that staff who were completing risk assessments had not received any training in writing risk assessments.

During our visit we looked at all bedrooms, except for two, and all of the communal areas at the service. We found that a number of rooms had exposed pipework leading to the radiator or a radiator that was not covered. We saw this in a total of nine bedrooms at the service. The pipes were very hot to the touch. A high number of people living at the home were at risk of falls. People were at risk because action had not been taken to mitigate the risks still present. We also noted that around the service there were a number of freestanding electric heaters in use. The risk assessments did not cover the use of these freestanding electric heaters and so no consideration had been given to whether these posed a risk to people, particularly those at risk of falls. In addition to this there were no restrictors on the windows, including those on the first floor. No risk assessment had been carried out with regard to this issue.

Improvements were needed in the management of risk to ensure that the premises were maintained, safe and fit for purpose. We spoke with the registered manager, who was also the providers representative on the day of our visit. We also spoke to the general manager who was responsible for the day to day running of the home. There was confusion about whose responsibility it was to carry out risk assessments and to review these although the registered manager agreed that it was his ultimate responsibility. He said that there were no formal checklists in place to ensure that this was carried out. There was also no formal plan in place for the on going maintenance of the building. The registered manager had started to take some action following an accident but this action was not taken in a timely way and had not been completed at the time of our visit.

One of the bedrooms had extensive black mould growing on the walls and across the small window that was situated in the en suite toilet. We raised this with the registered manager during our inspection and requested that he took immediate action to address this. The registered manager said that he was not aware of the issue. We looked at the record of room checks that the staff completed and the fact that there was a serious problem with mould in this room, this had not been identified on the records. The registered manager said that he would expect staff to notify him of any such concerns but that this had not happened.

We looked at the risk assessments for two people with regard to falls. We saw that these were brief and did not contain adequate information about the risks and control measures in place to reduce the risks.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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 did not take formal enforcement action at this stage. 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 Environmental risks had not been assessed and therefore action had not been taken to reduce the risks to people living at the home.