Laurel Lodge Care Home

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Inspection report

19 Ipswich Road
Norwich
Norfolk
NR2 2LN

Date of inspection visit:
17 May 2016

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23 June 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 17 May 2016 and was unannounced. It was carried out to establish whether improvements had been made regarding areas of concern that we identified at our previous two inspections. This report only covers our findings in relation to the key question of whether the service provided safe care.

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.

At the time of this inspection there was a registered manager in post. 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 2008 and associated Regulations about how the service is run. The registered manager was also a partner in the business and therefore the provider. The registered manager has been referred to as the provider throughout this report. There was also a home manager in post who was managing the home on a day to day basis. This person has been referred to as the home manager throughout this report.

When we inspected this service on 17 March 2016 in relation to the key question of safe, we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection we asked the provider to send us an action plan of how they intended to address the breach of the Regulation. We did not receive the action plan from the provider..

We then undertook a comprehensive inspection of this service on 26 April 2016. During this inspection we found a repeated breach of Regulation 12. We also found at that inspection breaches of Regulations 11 (consent), 12 (safe care and treatment), 15 (premises and equipment), 17 (good governance), 18 (staffing) and 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection we asked the provider to send us an action plan of how they intended to address the breaches of the Regulations. At the time of writing this report we had not yet received an action plan.

As a result of our inspection in April 2016 the service was placed in special measures.

We found during this inspection that the provider still did not ensure that all reasonable steps were taken to ensure the risks to people were minimised. Risk assessments were still inadequate. Where risks had been identified the provider had still not taken effective action to reduce the risks in a timely way.

You can read the report from both our focussed inspection on 17 March 2016 and our comprehensive inspection on 26 April 2016 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 following this inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from risks to their health and safety. Action was not taken when risks were identified.

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

This inspection was carried out by two inspectors and was unannounced.

Before our inspection we looked at information we held about the service including statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also obtained feedback from the local authority's quality assurance team, an Infection Prevention and Control Nurse working for public health at the local authority and also the fire service.

During our visit we spoke with the registered manager, the home manager, the assistant manager and three care staff.

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

Inadequate

Is the service safe?

Our findings

Our previous inspections on 17 March 2016 and 26 April 2016 identified a number of breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation relates to people receiving safe care and treatment. During this inspection we found that there was a continued breach of this regulation.

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 still not completed appropriately and still lacked detail. For example, some people still had portable electric heaters in their bedrooms. The provider told us that everyone who had a heater had a sign on their door to indicate that there was a heater in use in that room. However, we found that not all of the rooms where heaters were in use had been identified. We saw that risk assessments had now been put in place for the use of the heaters. However these were generic and did not look at individual's specific support needs. We found that staff who were completing risk assessments had still not received any training in writing risk assessments, however, they were being asked by the provider to write the assessments.

At our previous inspection in April 2016 we asked the provider to fit window restrictors to the windows above ground floor level which did not have restrictors fitted. We saw at this inspection that whilst some windows had since had restrictors fitted there were three windows that were above ground floor level which had not had restrictors fitted. These windows opened wide enough for someone to climb or fall through. There were still no risk assessments in place with regard to this issue.

At our previous inspection in April 2016, we saw that designated fire doors to two peoples' bedrooms were secured open using wooden door wedges and that another person had their fire door held open by their armchair which had been positioned to hold the door open. Following that inspection we spoke with the fire officer who visited the service to review fire arrangements. During this inspection we saw that the provider had taken some action to fit automatic door closers to the fire doors that we had highlighted as having being secured open. However, we saw at this inspection that another person's bedroom door was being secured open using a wooden door wedge.

The provider's fire risk assessment which was carried out in March 2015 identified that mobility aids and other items were blocking escape routes in the event of a fire. We saw that the provider had recorded that staff had been reminded about blocking the escape routes during March 2015. We saw during this inspection that two of the escape routes were partly blocked. One by a hoist and the other by a large ironing machine. This continued to present a risk to people living at the home in the event of a fire. We spoke to the fire safety officer again following our inspection to inform them of our concerns.

We looked in all of the bedrooms during our inspections and found that the provider had taken action to cover exposed radiators and pipework leading to the radiators. The provider told us that the remaining uncovered radiator in an upstairs bathroom was due to be covered and the necessary cover had been ordered. The provider told us that the bathroom would not be used by anyone whilst the radiator cover was ordered.

During the inspection we observed the housekeepers cleaning basket left in a corridor unattended for a period of time. We saw that amongst other cleaning chemicals, an open bottle of bleach was left in the basket. We observed staff and the provider walk past the basket a number of times without taking action. We asked the provider to ensure the cleaning chemicals were secured straight away.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we saw that the home manager and assistant manager were taking steps to complete the monthly premises check that they stated at our last inspection they would start. They had not, however, shared this information with the provider yet.

We saw at our inspection in March and April 2016 that three bedrooms had black mould growing on the walls. We saw at this inspection that the provider had taken some action to remove the mould from the walls; however the problem had not completely been eradicated.

One person had a piece of specialist equipment in their room which alerted staff if they had moved from their chair or bed. The equipment was not working on the day of the inspection. We spoke to three staff about what alternative arrangements were in place to keep this person safe whilst the equipment was repaired. All of the staff we spoke with knew that the person required additional checks and told us that the checks were happening. We saw, however, that records were not accurate and did not detail that the checks were being carried out.

At our previous inspections in March and April 2016 we saw a number of areas of the home that required redecoration or repair. We saw at this inspection that these concerns had not yet been addressed neither had a plan been put in place for the works to be completed. We found that there were still areas of the service that were in an unclean and poor condition.