Laurel Lodge Care Home

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Inspection report

19 Ipswich Road
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Date of inspection visit:
26 April 2016

Date of publication:
15 June 2016

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

Laurel Lodge Care Home provides nursing and personal care for up to 27 older people, some of whom may be living with dementia. There were 25 people living in the home on the day of our inspection.

This inspection took place on 26 April 2016 and was unannounced.

We previously undertook a comprehensive inspection at this service on 15 June 2015. At that inspection we found a breach of Regulation 11 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. During this inspection we found a repeated breach of Regulation 11.

We then inspected this service on 17 March 2016 in relation to the key question of whether the service provided safe care following a concern raised with us. At that inspection 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.

At the time of this inspection, in April 2016, 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.

The provider was not taking appropriate action to manage risks. Risks were not always identified and there was no clear guidance in place for staff to follow to manage all risks effectively. Risks around the accommodation were not identified and action was not taken in a timely way to reduce the risks to people living at the home.

There was no system in place to assess how many staff were required to meet people's needs effectively. Staff did not all receive the training and supervision that they needed to meet people's needs. Staff did not have a good understanding of the Mental Capacity Act and how this should be implemented to ensure people's rights were restricted lawfully.

Medicines were stored appropriately but there were unexplained gaps in the administration records. People were referred to healthcare professionals appropriately.

The home was not clean and not always well maintained. The was a lack of systems in place to prevent the risk of infection.

Improvements were needed with regard to the provision of meaningful activities for people to take part in.

The provider did not have an effective governance system to monitor the quality of the service and identify the risks to the health and safety of people. Effective audits were not being carried out. The provider had not picked up issues that were identified in this inspection and had not taken appropriate action to make improvements when we had identified them at previous inspections.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Recruitment arrangements were not always properly completed to make sure new staff were safe to work.

Gaps in medicines records had not been identified or acted upon.

Staffing levels were not always adequate to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Areas of the home were unclean and in poor condition.

Staff had not all received the training, guidance and support they needed to enable them to carry out their job effectively.

Staff did not understand the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards.

People's health needs were managed effectively. Health professionals were contacted when people became unwell.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

Relatives were positive about the care people received from staff and felt that they could visit at times of their choosing.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of meaningful activities for people to take part in.

People had information to help them make a complaint however recording of complaints was incomplete and complaints were not investigated.

People's needs were not always met.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not established quality assurance and risk management systems to effectively and consistently identify issues or to improve the service.

The provider had not taken action despite areas of improvement being identified in previous inspection reports.

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.

This inspection took place on 26 April 2016 and was unannounced.

This inspection was undertaken by two inspectors 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.

Before we carried out this inspection we reviewed the information we held about this service including notifications. A notification is information about events that the registered persons are required, by law, to tell us about. We also made contact with the local authority quality assurance team and infection control nurse to aid with our planning of this inspection.

During our inspection we spoke with nine people who lived in the service. We also spoke with three relatives. Throughout the inspection we observed how the staff interacted with people who lived at the service. Some people were not able to communicate their views of the service to us and therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spoke to the provider, the home manager, deputy manager and four staff who work at the service. During the inspection we looked at three people's care records and records in relation to the management of the service including staff recruitment records, staff supervisions, complaints and quality assurance records

Inadequate

Is the service safe?

Our findings

At our last inspection we found breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not ensure that all reasonable steps were taken to ensure the risks to people were minimised. We found at our last inspection that risk assessments were inadequate, did not consider the risks and did not provide clear guidance to staff about how to manage risks. We also found that where risks had been identified the provider had not taken action to reduce them in a timely way.

During this inspection in April 2016, we found that there was a continued breach of this Regulation. Whilst there were some risk assessments in place, the provider told us that their approach to risk assessments was a reactive one. This was opposed to a system where potential hazards are identified and control measures put in place to reduce the likelihood of the hazard causing harm. The provider told us, "There are risks at Laurel Lodge there but these are not always written down." We saw that the provider had, at our request, by 1 April 2016 re written the environmental risk assessment for the service. We found however, that not all of the identified actions had been taken in order to keep people safe.

We had concerns at our last inspection that despite an accident to one person, risk assessments had not been completed for the other people living in the home regarding the same risk and appropriate action had not been taken. One person experienced significant burns when they fell against exposed hot water pipes feeding a radiator. Following this accident we were assured by the provider on 18 March 2016 that all exposed hot water pipe work had been covered and that action was being taken to cover exposed radiators in the rest of the building. Appropriate action needed to take place to protect other people from the risk of a similar accident occurring. We went back to check that provider had carried out the works on 12 April 2016 and found there were still uncovered radiators and hot water pipes at the service. These were in areas such as people's bedrooms and en suite bathrooms. We were assured again that appropriate action would be taken, however at this inspection we found that a large radiator within a bathroom was uncovered and very hot to touch.

During our last inspection in March 2016 we also found that windows on the first floor at the service did not have restrictors on them. There were also no risk assessments in place which covered using or not using window restrictors. After asking the provider to respond to this concern we received confirmation on 15 April 2016 that all upstairs windows had been fitted with restrictors. We checked that all the window restrictors had been fitted when we carried out our inspection in April 2016.

There were no risk assessments completed to assess the risks of people having access to cleaning products. We found that there were some information data sheets available relating to cleaning products, but these were not included in any risk assessment's so that staff would know how to deal with spillages or accidents.

We saw that a fire risk assessment had been completed during March 2015 and should have been reviewed during March 2016 but had not been at the time of this inspection. We were told that this was the most up to date fire risk assessment available at the service. There were a number of actions devised as a result of the

fire risk assessment and we could see that the provider had recorded that some of the actions were complete. There were also, however, a number of actions where no action had been recorded. We tried to get clarity of these points following the inspection; however the provider was not available.

We saw that designated fire doors to two peoples' bedrooms were secured open using wooden door wedges. We saw another person had their fire door held open by their armchair which had been positioned to hold the door open. We were also told that the fire doors were being held open so that staff could easily check some people who were remaining in their bedrooms due to being unwell. This presented a risk to people living at the home in the event of a fire. The provider told us that they were aware of the legislation around fire doors however they had no intention of fitting automatic closers at present. We spoke to the fire safety officer following our inspection who told us they would visit the service to discuss arrangements for fire safety.

We looked at three people's nutritional risk assessments. We saw for one person that in March 2016 that they were assessed as a low risk. This was despite input from the dietician and continuous weight loss since May 2015. We saw that the same person had a nutritional care plan which stated the person was at high risk. As no action had been taken in response to this we were told the home manager had plans to restructure the way duties were allocated to staff to ensure that people had their nutritional needs met.

The home manager provided us with a copy of a cleaning schedule that had been developed. We saw that the cleaning schedule was not very detailed and did not provide domestic staff with sufficient information about the cleaning job to be undertaken or what process to follow. We saw that the toilet seats and pans were dirty in a number of bedrooms. We also observed poor hand hygiene practice by staff. For example we saw a member of the domestic team wore a pair of gloves to clean in one person's room and then kept the same gloves on as they moved around the service. There were not any wall mounted paper towel dispensers available in people's rooms. A roll of disposable paper was available for staff to dry their hands on and these were placed in people's rooms. This was important because it increased the risk of cross contamination when staff handled the paper roll which in turn could increase the risk of infection.

We saw on the house keeper's trolleys that the area where cleaning products and cloths were stored was not clean. We discussed this with the home manager, who acknowledged the trolley was dirty. We also observed that two disposable cloths were used in one person's room and then continued to be used in another person's room. People were at risk of the spread of infection. The home manager told us that one of the domestic team had attended a training day to become a 'champion' for infection control; however there had not been a proactive approach to promoting this within the service.

We were told that some people required support with mobilising and changing position. We saw that there was equipment in place to enable staff to support people with this. Records showed that hoists had been appropriately serviced. We saw however, that the slings which were used with a hoist had information labels on them that had faded and were no longer legible. This was important because the label on a sling tells the user the size of the sling, when it was last serviced and the serial number. There were no records of checks on the condition of the slings. The home manager told us that they had advised staff to do this before they used the slings but the checks were not recorded anywhere. A member of staff who had been designated to review the moving and handling techniques and processes told us that they had had training to do so prior to starting employment at this service. However the training was out of date and there had been no date arranged for them to do it again. We saw that the providers own training schedule stated that training in assisting people to move should be repeated by staff annually. We saw that there were a number of staff who had not had this training updated.

We spoke to a member of staff who told us that one person had their own personal slings however other people were sharing slings. The member of staff told us they were aware that people should have their own sling and had raised this with the provider. Not sharing slings is important because doing so increases the risk of transferring infection.

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

We looked at the arrangements in place to ensure staff were recruited safely and that people were protected from unsuitable staff. Some recruitment checks, such as proof of a prospective employee's identity had been satisfactorily documented. However, none of the staff files that we looked at showed evidence of a full employment history. There were gaps in employment history which meant that episodes of a person's possible employment may be unaccounted for. We looked at three staff files and saw that for each candidate only one reference was taken up. We also saw that Disclosure and Barring Service (DBS) checks for staff were not received back prior to the staff member commencing employment. The DBS provides a criminal record checks to help employers make safer recruitment decisions.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider confirmed that staffing levels were not formally assessed against the dependency levels of people who used the service. One person told us, "Staff here are quite good. They're always very busy. They do not have time to talk and I'm not sure they understand my needs. If you use the call bell you have to wait sometimes but they come with good excuses. Do you know there are only two on at night and there should be more. There really isn't enough time". Another person told us, "The staff don't have time to talk I'm afraid. If they did it would mean you could be a bit more aware of the world outside". We asked staff whether they thought there were enough of them on shift to meet people's needs. We were told by one member of staff, "There have been enough staff lately, and it has got better. We used to be short staffed." Another staff member told us, "We are often short staffed, particularly on the late shift. It means we can't look after them [people] as well as we want to. We don't get chance to talk to them [people] and we have to rush them." A third staff member told us, "It's been fraught lately. I haven't been able to sit with people as much. I try to get 10 minutes just before the end of my shift to talk to people. They get anxious if they don't see any staff for a while."

We were told that the home employed three housekeeping staff who each worked four hours a day on a Monday through to Friday. There were no housekeeping staff employed during the weekend. We were told that the care staff were expected to carry out cleaning tasks at the weekends in addition to their care work.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told by one person, "Yes, I'm alright here. Staff are alright." Another person told us, "Oh yes, I'm very safe." The staff we spoke with told us that they had received safeguarding training, although some could not recall how long ago this was. All staff we spoke with knew some of the different types of abuse and could describe how they would recognise the signs of abuse and how they would report it within the service. No staff member that we spoke with one was clear on the role of the local authority safeguarding team and how they would contact them. However, all staff told us they knew how to access information about safeguarding that was held in the office.

We looked at how medicines were managed. Senior staff were able to explain in detail how medicines were managed in the service from ordering, to when they were delivered and when they were returned to the pharmacy. When we looked at the medicine administration records (MAR) charts we saw a number of unexplained gaps in the records. The provider had recently started to carry out an audit of medicines held in the home, but the audits had failed to pick up missing signatures or instances where staff had failed to record the reason for the gaps. We were told that there were a number of staff who administer medicines to people following training to do so. We were told that staff undertook this training annually however when we saw the training was either out of date or no date was listed for all staff at the service.

Requires Improvement

Is the service effective?

Our findings

The staff and manager told us that there were people who lived at the service who lacked capacity to make decisions about their care. Therefore they had to work within the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who 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. Where people lack mental capacity to make particular decisions, any made on their behalf must be made in their best interests and be the 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 MCA. The application for these procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found evidence that the service was not working within the principles of the MCA.

During our inspection on 11 June 2015 we found that people could not be assured that they were supported by staff who understood the MCA and DoLS. This meant that the provider was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, We asked the provider for an action plan to outline when they would make the required changes however we did not receive one.

During this inspection we found that some staff had received training in, and had a basic understanding of MCA and DoLS. However all of the staff we spoke with told us that they had heard of MCA and DoLS however they were not clear what it meant in practice at the service. We asked staff about people who may try to leave the service or who may be under constant supervision. We were told by the staff we spoke to that the front door needed to be locked shut to protect people and that one person was stopped from leaving when they tried to do so. We saw that there was no DoLS in place for this person and that one had not been applied for yet. The home manager and deputy manager told us that they had recognised this and were in the process of applying for a DoLS authorisation.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 17 March 2016 we saw that 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. At that inspection we raised this with the provider and requested that they took immediate action to address it. At this inspection we saw that black mould had begun to re-appear in the same room plus we saw black mould in a further three rooms. The provider told us at the last inspection that they were not aware of the mould prior to us pointing it out to them and that he would ensure a record of room checks would be put in place. At this inspection he told us that he wasn't aware that it was an issue again. We were told that the record of room checks that had been put in place for staff to complete had not been completed or carried out.

The provider told us that he was aware that work needed to be done to the outside walls of the property. However he told us he could not access the land next door to the service to make the required repairs.

We saw a number of areas of the home that required redecoration or repair. For example we saw paint work scuffed in communal areas and in several bedrooms we saw paint blistered and peeling off the walls and ceiling. We also saw extensive cracked plaster in a number of bedrooms. The provider told us that bedrooms were decorated when people vacated them but had no schedule of when other works would be completed. We saw that there was a record of items around the service for repair which was completed by care staff, this record included when the work had to be completed. The home manager and deputy manager told us that they did not have access to an overall maintenance plan for the home as the provider, "Keeps that information in his head and doesn't write it down anywhere." The provider confirmed that this was his approach. We asked the provider about whether he recorded his maintenance plan and approach to reducing risk and he told us, "No I'm not good at that, I do it in my head."

We found that areas of the service were in an unclean and poor condition. We also saw that there were areas with cobwebs and areas that were dusty.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us that they had access to training in order to carry out their role, although they were not always clear how long it had been since they received the training. We were told by the co-ordinator who oversaw the training that the provider had recently moved to a new online training provision. We were also told that all staff were undertaking training using the new system and that assessments of knowledge were completed and sent to the training company for assessment. We looked at the training matrix, which the training co-ordinator told us was the most up to date. We saw that there were a number of staff whose training was out of date or had not yet been completed according to the providers own training plan. The out of date training was in areas such as assisting people with moving, first aid, fire safety and safeguarding people from harm.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from the records we looked at that staff were not supported in their practice or development through regular one to one supervision. We asked staff about the support that they received from the home manager and provider. We were told by one member of staff, "I am due to have one [supervision], it will be the first for a long time. I think we have them [supervision] every 12 months." Another staff member told us, "I have only ever had a supervision when I first started here and that was over two years ago. There is not time to meet with a manager." Records confirmed that staff supervisions did not happen very frequently. One staff member told us they had no opportunity to discuss with their line manager their personal development and training needs.

We looked at three people's care plans and saw that capacity assessments had been completed appropriately. We saw staff ask people for their consent before they were supported. One person told us, "We do what we want. You can sit here in the lounge or go to your bedroom, there are no restrictions. You get up when you want; they [staff] just help you." Another person told us, "Bedtime and getting up is of my own choosing and I choose what I eat and when."

We observed people being supported with meals and drinks at lunch time. We saw that a member of staff

sat with some people and assisted them in a patient and respectful manner. People gave us mixed feedback about the food. Some people told us that they had a choice of food and if they didn't like what was available on the menu that day they were offered an alternative. We were told by one person, "The food is very good here, and they make you tea when you want it." Another person said, "The food is not good all the time." A third person said, "The food could be better. There could be more choice. It would be good if we could have pizza or noodles plus salads. I love salads." We asked staff about whether people had a choice of food. We were told by one staff member that it depended who was working in the kitchen as to whether or not people had a choice. On another occasion whilst one person was eating their soup for tea in the lounge when they were asked if they were enjoying their food. The person replied, "No it's too peppery, I am not fond of pepper." The member of staff asking the question responded by saying, "Oh dear" they then continued to offer the person the soup. This person did not have any alternative offered to them.

There was evidence within people's care records that the provider worked collaboratively with healthcare professional's such as the GP and community nurses. People told us that they were able to see their doctor or a nurse. One person told us, "The GP comes to the home. The staff organise all that for me." We saw records that showed us people had been referred for support from other healthcare professionals such as the dietician and speech and language therapist.

Requires Improvement

Is the service caring?

Our findings

We found people's experiences of the care they received were varied. We received mixed feedback from people about whether they were treated with dignity and respect. One person told us, "With kindness yes, but they [care staff] are always very busy. They rush me at times and should cover me up a bit more. They do knock my door yes, but they don't wait, they come straight in". Another person said, "They [care staff] treat me with kindness, they're very caring. They generally knock on my door before coming in". A third person said, "They usually knock and check if it's okay to come in".

We saw one person who was sitting in the lounge repeatedly call out to staff, "Are they coming with my tablets yet, I've got a terrible headache. I want to go to bed early and I have been asking for a long time." We saw that this person was told by both of the two care staff on duty that they had to wait until the senior staff brought their medicine. On a number of occasions they were prompted to sit down again in their chair. Neither of the two staff went to find the senior staff to see how long the person would need to wait. We saw on another occasion a person sitting on a hoist sling in their wheelchair for several hours without being moved. The same person was not always covered up appropriately in order to maintain their dignity.

On passing some people's rooms and whilst talking to people in their rooms we observed a number of signs put up to provide instruction to staff about how to care for that person or other general instructions. This was not respectful of people's right to dignity or privacy as it gave details of their personal care needs.

At times we also saw some caring interactions between people and staff. One person who was becoming distressed about why they were at the service and not in their home was comforted by a member staff whose response settled the person quickly. During our observations at lunch time we saw a member staff supporting a person who had difficulties with their sight, they were supported discretely to identify the food on their plate by a staff member who described the position of the food on the plate by using the clock, "Carrots at six o'clock and chicken pie at one o'clock," This was well received by the person they were supporting.

During this inspection we received positive feedback from the visiting relatives of two people. One relative told us how their family member was cared for by staff who were, "Lovely, kind hearted and well meaning." Another relative told us, "The staff here are kind and caring."

We asked people who used the service if they were involved in planning their care and if they knew about their support plan. People we spoke with all told us that they did not want to be involved and two people told us they wanted to rely on their families to sort their support plans out.

We were told that the assistant manager was developing a new care plan for one person. We saw that it was detailed and based on the preference of the individual. The person who the plan belonged to had been involved in writing it and had signed it.

Throughout the day of our inspection we saw visitors coming freely into the service. People told us there

were no restrictions on when they had their family and friends come to visit. We saw that there were meetings held at the service when families could attend with people. Minutes showed us that these meetings were an opportunity for two way feedback between the service, people and their relatives.

Requires Improvement

Is the service responsive?

Our findings

The home manager told us the service employed an activities co-ordinator on a part-time basis – for two days per week. We carried out our inspection on a Tuesday and observed no activities taking place apart from people sitting in the lounge with the TV on. We observed a number of people spending long periods either alone in their bedrooms or sitting in the same chair for two to three hours with no activities apart from the television. We asked people using the service what activities were on offer to keep them occupied. We were told, "We have music, quizzes and bingo here in the lounge." Another person told us, "I am friends with [other people]; we go to the quizzes in the lounge. There isn't bingo. I watch TV in my room, I enjoy Countdown". A third person said, "I get a bit bored, though I have my radio."

One person told us that they would like to watch TV in their room but couldn't because of the layout of their bedroom. They said, "I can't watch TV now as it's too far away. I only have the radio because I can't read because of my sight problems". We observed that the person's chair was one side of the bed near the window and the TV was on the other side. We asked the person if they had made the staff aware and they told us they had but nothing had been changed yet.

We asked people if they received the care they wanted to have. One person told us, "They're [staff] busy but I think so, yes." Another person told us, "There's no time. They [staff] are always rushing. We spoke with another person who told us that they wanted to have a shower everyday but was only supported to have one once a week. They said, "I have a shower every Thursday, when I have my hair done, well that's when there is hot water. Sometimes I am told there is not enough hot water, so I can't have a shower. I only have one shower a week, but would prefer to have one every day." The home manager confirmed that there were days when there was insufficient hot water. Another person told us that they had underfloor heating in their room and they were cold at times. We were told that only the provider had access to the heating controls. The home manager confirmed that the provider was the only person who could adjust the heating controls in some of the rooms. We were told that the provider would need to be called in to the service if the heating required adjustment. This was not very responsive and did not enable the temperature to be adjusted very quickly. The person told us that staff helped them with additional blankets at night when they were cold.

We saw people sitting in one place for a long period of time. We observed one person sitting in their wheelchair in the lounge for over four hours, during this time they had one magazine to look at and the television was on, they were not however supported to be sitting at an angle where they could see the television very well. We saw another person regularly standing up and asking for people or medicine. We saw that the staff response was to encourage this person to sit down again and wait. We were told by a visiting relative, "Some of the people in the lounge worry me, I always see them sitting in wheelchairs, and they spend a long time sitting in a wheelchair." One person told us, "I can't be independent anymore, sadly. I just sit here in my room now."

We also received positive comments. We were told by a person, "I wasn't sure what it would be like to live in a home like this. What I like about being here is when my door is closed I can get some privacy. I listen to

the radio and watch TV a lot in peace and quiet. They show respect in all ways. Bedtime and getting up is of my own choosing and I choose what I eat and when, and they bring me in drinks." Another person told us, "I'm made to feel very much in control of what I do with my time. My friends come and I'm quite content here."

We observed one staff member encouraging a person to be independent after they had asked for a wheelchair to take them from the dining room after lunch. The member of staff explained that it was better for the person to walk with their frame if possible. We saw that the person did walk with their frame, supported by the staff.

We looked at three people's support plans. We saw that these had been recently reviewed and updated. We found that the information within the care plans was up to date and relevant to the person the care plan belonged to. People we spoke with told us that they did not want to know about their support plan. One person said, "No, I'm not bothered." Another person said, "I think everything's in order. They seem to know what they're doing here."

We were told that five people had pressure ulcers. We saw that those people had regular contact with the district nurses with regard to treatment of their pressure ulcers. We also saw that people were supported with the necessary equipment to assist their healing and that this was included in their care plan.

The registered provider had a procedure in place to receive and respond to complaints; this was updated during April 2016. The complaints procedure contained details of how to complain to the provider, included CQC details and the Local Government Ombudsmen (LGO) details. The LGO looks at and investigates complaints about adult social care providers such as care homes and home care providers. We saw that a copy of the complaints procedure was displayed in the entrance to the service. This gave people the opportunity to raise concerns if they wanted to. We were told by the home manager that no complaints had been received at the service apart from, "minor grumbles about the laundry." One person told us that they had complained about the lack of hot water. This was not recorded as a complaint and there was no record of action taken. We asked other people whether they had made a complaint. One person said, "I'm happy enough; I've got nothing to complain about." Another said, "I would tell my daughter, she would sort it out."

Inadequate

Is the service well-led?

Our findings

Despite a serious accident occurring to one of the people living at the service effective action had not taken place to reduce the risks to other people living at the service. We carried out an inspection on 17 March 2016 and despite being told by the provider that they were taking appropriate action following our visit we found that they had not done so. We went back on 12 April 2016 and saw that the provider had still failed to take all the action needed to reduce the risks of another accident of the same nature occurring again. When we carried out this inspection we saw that some action had been taken however there were still some works to complete and some residual works remaining. During this time the provider had been telling us that he had completed the necessary works.

The provider agreed that processes were not in place for effective risk assessment. We saw during our inspection in March 2016 that there were no window restrictors on the first floor windows. We were told by the provider, "There are risks at Laurel Lodge Care Home but these are not always written down." The provider also said, "The window restrictors were not fitted as my assessment of people falling from windows was in my head. It is all in my head and not on paper."

We saw that a number of fire doors were being held open with door wedges. The provider told us that they were aware that this was not acceptable practice and that it was not in line with the fire risk assessment. However there were no plans to place automatic fire door closers on people's doors. We saw that even when identified and agreed improvements were needed the provider said he wouldn't take action due to financial reasons.

We saw that an audit of the medicines had taken place, however this was not was effective because it did not pick up a number of gaps in staffing signing for medicines administration that we identified at inspection. We spoke with the staff member responsible for the medicines who told us that there was no system for addressing missing signatures. We were also told that staff were permitted to sign medicines administration records retrospectively. This meant that they were able to sign for medicines a number of days after it should have been signed for. A pharmacist advice visit had been carried out by the supplying pharmacy during June 2015. This audit of the medicines had also identified that records of administration contained gaps. We could not be assured that people were receiving their medicines safely. There were no processes in place to audit medicines and to manage staff who failed to sign the MAR charts.

We found that no other audits were carried out to demonstrate how the quality of the service was being monitored and to identify where improvements were needed.

We found that checks on the environment were not taking place and this meant that the service was not always made safe for people. This was because systems were not in place to effectively identify and assess risk to the health, safety and welfare of the people who use the
service. During the inspection we also found issues in a number of areas such as infection prevention, dignity in care, medication, issues with the environment, staff training and staffing levels that had not been

identified by the provider.

We saw that accident and incidents were recorded by staff however there were no analysis of the accidents or incidents in order to identify residual risk and prevent similar accidents occurring again. This was despite some people being at high risk of falls.

People's views were sought in a questionnaire in 2015. However there was not an action plan developed as a result of people's feedback.

These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was also the registered manager; however they did not run the service on a day to day basis. The home manager was employed to run the service on day to day basis. The home manager however did not have access to all of the information needed. Some of the information was held by the provider and was not easily accessible.

Some people told us that they knew who the provider was. One person said, "I know [provider]. You can ask to see him". A second person said, "Yes, they [provider] comes in to talk." Another person said that they did not know who the provider was.

We saw the home manager engaging with people naturally and with compassion. People responded positively to this interaction, smiling and laughing. It was not clear that people knew what roles the provider and the home manager had or who they should approach if they had any concerns.

We saw from records that staff team meetings were taking place. Staff confirmed this. We viewed a copy of the minutes from the staff meeting held in March 2016. We saw that the meetings were an opportunity for information to be relayed to care staff. We saw that discussions had taken place to updated staff about various aspects of the service.

We were told by staff that they felt confident to raise any concerns with one of the management team. One member of staff said, "The managers [provider and home manager] are in most days. If I ask them anything they usually sort it and get back to me." Another staff member said, "You can talk to them [home manager], they are here." A third staff member told us, "The manager [home manager] is approachable. I could talk to them [home manager] if I had any concerns."

Providers are required to send the CQC statutory notifications to inform us of certain incidents, events and changes that happen with a service. A notification is information about important events that the provider is required by law to notify us about. Records, and our discussions with the home manager, showed us that notifications had been sent as required.