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The Langleys

Inspection report

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 14 February and 12 March 2018 and was unannounced on both days.

The Langleys is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Langley's provides care and accommodation for up to 15 older people. There were 10 people living in the home at the time of our first visit and 11 people during our second visit.

At our last inspection in November 2016 we found there were improvements needed in four of the key questions we inspected these were Safe, Effective, Responsive and Well led. No breaches of regulations were identified at that time. We rated the service 'requires improvement' overall. During this inspection improvements had not been made to improve the ratings and we identified additional areas needed improvement. We have therefore rated the service as 'Inadequate'.

The service is required to have 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 and associated Regulations about how the service is run. Since our last inspection the management at the home had changed. The previous registered manager had left their employment in August 2017. A new manager had been in post for three months at the time of our visit and was in the process of applying to register with us.

Systems and processes had not been established or managed effectively to monitor, assess and improve the quality and safety of the services provided. The provider had not identified or taken action to mitigate risks in relation to the fire safety at the home which placed people at serious risk. We formally wrote to the provider and asked them to take immediate action to reduce these risks. Sufficient action was taken and this was confirmed by the Fire Safety team. Some health and safety risks in the home had not been identified and managed to keep people safe. The home was not clean and staff practices did not always protect people from the risk of infection.

Most people received their medicines when they needed them but the storage of medicines was not safe. Medicine audits took place but had not identified areas that required improvement.

Risk assessments to manage risks associated with people's care were not effective. Some information recorded was incorrect and important information was not always available to support staff to provide safe, consistent care.

There was not enough staff on duty to meet people's needs in a timely way. The system the provider used to

assess how many staff were needed to support people safely was not effective. Staff had not completed all of the training they needed to meet people's individual needs. Staff members spoke positively about the manager and provider but told us they would feel more supported if more staff were on duty.

People's rights were not always protected because the provider continued not to work in line with the requirements of the Mental Capacity Act (2005). Staff did not demonstrate to us they understood the principles of the MCA but they did seek peoples consent before they provided assistance.

The provider did not understand the requirement of their registration which placed people at risk of harm. Assessments of people's needs took place before people moved into the home but these assessments had not gathered enough information to ensure people's needs could be met at the home. People told us they had not been involved in planning and reviewing their care.

The information contained with people's care plans was not sufficient to support staff to provide care in-line with people's preferences and wishes. The arrangements to check the quality of people's care plans were not effective. The manager did not demonstrate they understood people's needs. We were not assured the manager had sufficient knowledge of best practice and legislation to continually improve the service provided.

People's privacy and dignity was not always maintained. Staff did not understand the importance and principles of equality and diversity as part of a caring approach. Staff did support some people to be as independent as they wished to be. However, the layout and facilities at the home were not suitable to meet some people's needs.

People told us there was not enough to do to occupy their time. We found no improvements had been made the social activities provided to people since our last inspection.

People provided positive feedback about the food but we saw the mealtime experience was not positive for all people. Staff did not demonstrate they understood how to provide specialised diets.

There were ineffective systems to seek feedback from people about the service they received to drive forward improvements. It was not evident the home worked in partnership with the local community to enhance people's lives.

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. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

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.

In response to the concerns identified, the provider has taken the decision not to admit further people into

the care home until improvements are made. Local Authority commissioners are supporting the provider to bring about improvements required.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Systems to identify and manage risk at the home were not effective. Staff did not always manage risk safely. There were not enough staff to meet people's needs in a timely way. Staff had not completed the training they needed to meet people's needs. The home was not clean and people were not always protected from the risk of infection. Recruitment procedures minimised the risks to people's safety. People received their medicines as prescribed but the storage of medicines was not safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received support when they first started work at the home. Staff did not have opportunities to complete on-going training to meet people's needs. The provider was not working within the requirements of the Mental Capacity Act (2005). Staff did not understand the principles of the act. People enjoyed the food but the mealtime experience was not positive for all people. People received the support they needed from health professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most people spoke positively about the staff. However, some people did not experience positive care. People's right to privacy was not respected by the manager or the staff. People's dignity was not always maintained. Staff did not understand the importance of equality and diversity. Staff supported people to be independent as they wished to be.

Is the service responsive?

Inadequate

The service was not responsive.

Staff were not always available when people needed them. People told us they hadn't been involved in decisions about their care. Some care plans lacked detail and contained incorrect

information. People were not satisfied with the social activities. Some people's needs were not met by the design of the home. There was a complaints process in place and people felt confident their complaints would be dealt with.

Is the service well-led?

Inadequate

The service was not well led.

The home was not effectively managed and it was not evident the manager kept their knowledge of best practice and legislation up to date. Systems and processes to monitor the quality and safety of care were not effective to drive improvements. Risk management at the home was not sufficient. The provider did not fully understand the requirements of their registration which placed people at risk. Process to seek people's feedback was ineffective. Staff spoke positively about the manager.

The Langleys

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 unannounced comprehensive inspection took place on 14 February and 12 March 2018. The inspection team consisted of two inspectors on the first day and one inspector on the second day.

Before our visit we reviewed the information we held about the service. We looked at the statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

We also spoke to the local authority commissioning team. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority. They informed us they had visited the home on two occasions in January 2018. They shared information of concern with us in relation the quality of care provided, the safety of the environment and the leadership of the home. They had requested an improvement action plan from the provider and were working closely with the home manager to improve the service people received.

The provider had completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. However, this information did not consistently reflect the service we saw.

During our first visit we spoke with six people who lived at the home and one visiting health professional. We also spoke with the home manager, one senior care worker and three care workers. During our second visit we spoke with two people who lived at the home, two care workers and one domestic assistant.

We reviewed six people's care records to see how their care and support was planned and delivered. We looked at two staff records to check whether staff had been recruited safely and were trained to deliver the

care and support people required.

We looked at other records related to people's care and how the service operated, including the service's quality assurance audits and records of complaints.

Inadequate

Is the service safe?

Our findings

At our last inspection in November 2016 we rated 'safe' as 'requires improvement'. At this inspection, we found action to make and sustain improvements had not been made.

During our first visit we identified serious concerns in relation to the fire safety at the home. A fire risk assessment was not in place. A fire risk assessment assists in ensuring the removal or reduction of the risk of hazards and determines what safety measures are needed to ensure the safety of people, visitors and staff in the home, in the event of a fire.

Emergency fire exit doors were not fully operational. We saw the fire door located nearest to the lounge was locked. Access to the fire door was also obstructed by a large number of coats hanging on a coat rail in the hallway near to the fire exit. This meant people could not gain access to the door to evacuate the building quickly and safely. The door located nearest to the kitchen of the home was difficult to open. We found it required significant force when we went to open it. The manager and staff acknowledged that the door would be difficult for some people living at the home to open should they need to evacuate the building in an emergency situation. This meant the provider had failed to assess and mitigate risks in relation to the fire safety. This had placed people at potential significant risk of harm. During our second visit we checked and found these risks had been removed because we found fire doors were unlocked, the coat rail had been removed and the door located nearest the kitchen opened easily.

On the first day of our visit in the home's cellar we saw surface water from an unknown source covered a large area of the floor. This presented a potential serious risk because we saw electrical items were plugged in to the electrical sockets in this area. This issue had already been bought to the provider's attention by the Local Authority on 19 January 2018. However, no action had been taken by the provider to rectify this issue. During our second visit we were made aware the provider had obtained quotes for the remedial work but this work had not yet been completed.

During our first visit we asked the provider to take immediate action to reduce these serious risks. We also formally wrote to the provider and asked them to submit an urgent action plan to tell us how they were going to do this. The provider's response assured serious immediate risks had been mitigated to keep people safe.

Due to the seriousness of our concerns the day after our first visit we contacted the West Midlands Fire Service and requested they visited the home to inspect and evaluate fire safety. Fire Officers visited the home on 15 February 2018. They informed us whilst serious risks had been removed the provider needed to take further action to keep people safe. This action included implementing a fire risk assessment and improving the planning, organising, controlling, monitoring and reviewing the performance of each of the fire safety measures in place. The fire service advised us they would revisit the home to ensure action had been completed.

We found some health and safety risks around the home to keep people safe had not been identified or

managed effectively. For example, an environment audit completed by the manager on 28 November 2017 had not identified there was an iron hung on the wall in a communal area of the home which could cause serious injury if it fell. We saw the cupboard which contained the home's hot water boiler which was also located in a communal area was not locked. This presented a risk because the hot water pipes were extremely hot and could cause significant harm to people should they touch the pipes. We bought these issues to the attention of the manager who removed the iron from the wall and fitted a locked padlock to the cupboard door.

Throughout the home there was a need for refurbishment and improvement to the décor to benefit people and keep them safe. We saw some carpets which were thread bear. Other carpets were not fitted securely to the stairs or the floor. These risks had been identified by the manager in November 2017 but no action had been taken to repair or replace the carpets. This presented a risk because people might trip on the carpet and be injured. We discussed this with the manager who acknowledged this was a risk and told us they had discussed this with the provider. They told us they would speak to the provider again to discuss replacing the carpets in the home.

We saw people lived in an environment that was not always clean and staff practices did not always protect people from the risks of infection. For example, one person's mattress required cleaning daily. A cleaning checklist was in place to ensure this happened. Cleaning records we looked at showed staff had completed the checklist between 27 January and 5 February 2018 to confirm they had opened the mattress zip and inspected the mattress for stains and water damaged. However, we found these checks were not effective. This was because we saw the inside of the mattress cover was visibly stained with an unknown fluid. We found stale food items and dirty crockery located underneath the person's bed. We discussed this with the manager who immediately removed the items. They explained they had already arranged for further infection prevention control training to take place with staff because they had identified cleanliness of the home needed to be improved and maintained.

We looked at systems to manage the risks associated with people's care. At our last inspection visit we were satisfied people's risks were managed safely, however during these visits we found this was not always the case. This was because some information in people's care records about their risks were incorrect and some important information was not recorded to support staff to provide safe, consistent care. For example, staff told us one person became anxious and on occasions displayed behaviours that could cause distress to others. A risk assessment was not in place for staff to follow to manage this behaviour. This was in despite of the person's care plan being reviewed in January 2018 which had identified that this behaviour caused other people who lived at the home to feel frightened.

This same person's risk assessment informed us how they were supported by staff to have a bath. However, staff told us this information was incorrect because they often refused their assistance to bathe. Therefore, to maintain the person's personal hygiene staff supported them to have a 'bed bath' every day. This important information was not recorded. As the risk assessment was not accurate this presented a risk this person's care may not be consistently managed safely by staff. The manager told us during our first visit they would review and update the person's risk assessments to reflect the risks correctly. During our second visit we checked to make sure this had been done. We found the risk assessment had not been updated.

Another person had been admitted to hospital on 5 March 2018. When they had returned to the home their support needs had changed because they required assistance from to staff and district nurses to manage their urinary catheter. Whilst district nurses had overall responsibility for managing the catheter, staff in the home provided every day care and assistance. There was no care plan in place informing staff how to provide that daily assistance or the signs they needed to look for to indicate the catheter might not be

working correctly.

Despite staff telling us they were aware of risks associated with people's care we saw they did not always manage risks safely. For example, one person told us, and their risk assessment confirmed they required staff to use a piece of equipment to help them to move safely. However, we observed two staff members attempted twice to assist the person to move without using the equipment. We had to intervene to prevent the person from being injured. We immediately bought this to the attention of the manager who acknowledged this had placed the person at risk of harm. They told us they would address this issue with the staff team. Following our visit we made a referral to the local authority safeguarding team to ensure the risk to this person's safety could be followed up.

At our previous inspection we had some concerns about the administration of medicines. During this visit we continued to have concerns about how some medicines were administered and stored. People's medicines were not consistently stored safely. For example, we saw the trolley containing people's prescribed medicines had been left unattended in the dining room by a staff member and the keys had been left in the lock. The fridge in the dining room which contained medicines was not locked. A staff member told us this was because the Pharmacy had provided the fridge to the home without a key. However, staff told us no action had been taken to request a key. The manager told us they would take action to resolve this. During our second visit we saw the fridge remained unlocked.

Some people were prescribed creams to be applied directly to their skin. We checked and found most of these had been administered correctly. However, one person had been prescribed cream that needed to be applied once a day, but medicine administration records we looked at during our first visit showed us this cream had been applied twice a day. We checked with staff and they confirmed they applied the cream twice a day. We asked if this had been agreed with the persons' GP, and a staff member replied, "No." They assured us they would speak with the person's GP to check that applying the cream twice a day was safe.

Audits to ensure medicines were being managed, stored and administered safely were not always effective. For example, daily audits completed in December 2017 had not identified items including flammable lighter fuel were stored within the same cupboard as medicines which presented a risk. We saw these items remained in the cupboard during our visit. The manager removed these items on our request and commented. "I did not know they were there." A staff member explained they knew the lighter fuel had been in the cupboard for approximately three months but they had not removed it because they didn't know where else to store it.

This was a breach of regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment

At our last inspection we found there were sufficient staff to meet people's needs. During this inspection people told us there was not enough staff to meet their needs in a timely way. Two people explained this made them feel unhappy because they were unable to leave the home when they wanted to because staff were not available to take them.

We saw during both of our visits how the insufficient numbers of staff on duty impacted negatively on people's experience of living in the home. During our first visit staffing levels consisted of two care workers, a part time domestic assistant and the manager. This was to support 10 people with a variety of complex of needs. We saw some people waited for over 30 minutes seated in the dining room for their meals to be served at lunchtime. People had to wait because one care worker who was responsible for preparing and serving meals was busy administering people's medicines. On another occasion we saw a staff member

forgot to provide a person with a drink because they were busy providing assistance to another person. We spoke to the care worker about this and they explained they had 'simply forgot' to make the person a drink because they had needed to responded to another person's call bell. We saw the person was unable to make a drink for themselves and we did not observe they were offered another drink until nearly two hours later.

During our second visit the manager was not at work. This meant two care workers and one domestic assistant were on duty to support 11 people. We saw on one occasion a person was not provided with the reassurance they needed to make them feel safe. We saw the person was crying and we heard them say, "I'm scared, I don't like it here, I want to go home." Both care workers on duty were busy assisting another person at this time and we saw a domestic assistant stopped what they were doing to provide the person with reassurance. We spoke with a care worker about this person and they said, "They (Person) do get tearful, I think they are a bit scared but because they are new here but we can't always be there when they need us."

During both of our visits all of the staff we spoke with told us it was difficult to provide safe care in a timely way to people alongside completing their 'non caring duties'. These duties included preparing people's meals and completing laundry duties. Comments included, "It's hard especially at the weekend," "We need more staff." And, "We cope. It's hard doing the cooking and care but we just manage. We always have done."

Three people who lived at the home needed two staff to assist them to move. We asked staff what happened with people who required support from two staff members when one staff member was busy undertaking non caring duties. One said, "If they [people] need the toilet we could ask the manager to help if they are here. At a weekend it's a problem but I would just have to leave the kitchen." Another told us, "We take them (people) to the toilet before going into the kitchen so they won't need to go."

We shared our concerns in relation to staff being unavailable when people needed them with the manager during our first visit. During the morning they assured us there was enough staff on duty to meet people's needs. They told us, "We use a dependency tool. There is two staff, it's enough." (A dependency tool is used to assess people's level of needs to determine required staffing levels.) This tool had been implemented since our last visit when we found the number of staff on duty were not based on the levels of need and the previous manager did not use a 'dependency tool'. We looked at the dependency tool used but it did not reflect people's needs. For example, we were aware one person had a urinary catheter and needed assistance from staff to manage this but this was not reflected. It was also unclear how the information had been used to determine the staffing levels at the home. During the afternoon the manager informed us they were going to approach the provider and ask for more staff to be on duty to ensure people's needs were met in a timely way. We asked the manager to inform us of the provider's response to this request. During our second visit we spoke to the manager over the telephone and they told us they had not yet had the opportunity to discuss increasing the staffing levels with the provider. Due to our concerns we asked them to speak with the provider immediately and inform us of their response. They agreed to do this.

Staff who prepared people's meals told us they had not completed any training or qualifications to support them to carry out the role safely. During our second visit we saw people's meals were 'plated up' in the kitchen at 12:20pm and some people were not served their meal until 12:40pm. We were concerned because a process to check people's meals were served at a safe temperature was not in place. This presented a risk that food could be served cold which meant people might not enjoy their meal.

It is it is important that foods requiring refrigeration are stored between acceptable ranges to ensure it remains safe to eat. However, some staff were not aware of the correct temperature that these foods needed to be stored at which was a potential risk. For example, one said, "To be honest I'm not sure. I just

follow what has been recorded and if it was really different I would tell the manager."

Staff told us and records showed they had not received training to support them to meet people's individual needs. For example, staff had not completed training in catheter care or supporting people living with a learning disability. This meant staff did not have the knowledge and skills required to meet the needs people who lived at the home.

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

We reviewed medication records for five people and saw those people had received their medicines as prescribed to maintain their health. This had improved since our last inspection when we found some information recorded on medicine administration records (MAR) was not legible. Staff told us they had completed training to administer people's medicines safely and records confirmed the manager completed observations of their practices to ensure they remained competent to do so. We saw a staff member followed good practice when they administered people's medicines. They took medicines to people, told then what it was for, provided them with a drink and watched them take their medicine before returning to sign the MAR to confirm they had taken it.

During our last inspection staff were not aware of the safeguarding processes they needed to follow in the absence of the manager. During this inspection we found this had improved. One staff member told us, "We write everything down and tell the manager. If they were not here I would call you (CQC) or the social workers." The manager demonstrated they understood how to report safeguarding concerns to the local authority so allegations of abuse could be investigated if required. Staff were aware of their responsibilities to protect people from harm and knew they needed to report any concerns to the manager. One said, "If I saw bruising I would tell the manager and they would sort it out."

A system to monitor accidents and incidents that happened in the home was in place. Records showed none had occurred since our last inspection. The manager assured us they would analyse any accidents that occurred and take action to prevent them happening again.

Recruitment practices minimised risks to people's safety. The provider ensured, as far as possible, only staff of suitable character were employed. Prior to staff working at the home, the provider checked their suitability by contacting their previous employers and the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. Staff told us they had to wait for DBS checks and references to come through before they started working in the home.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in November 2016 we rated 'effective' as 'requires improvement' because the requirements of the Mental Capacity Act were not always being followed. At this inspection, we found improvements were still 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When people 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection we identified the requirements of the Act were not always followed. This was because we found some people had been incorrectly assessed as not having capacity to make decisions. During this inspection records showed improvement had been made because people's capacity had been correctly assessed. However, further improvement was required because we saw that people were subject to a restriction of a locked front door but DoLS applications had not been submitted for people as required, to authorise the restriction. This showed us people's rights were not always protected and the provider and manager did not understand their responsibilities in relation to the requirements of the MCA. The manager said, "I'll be honest, it's not my strongest point but I'm learning. I've booked some more training for myself and the staff to attend at the end of the month." During our second visit records showed us this training had been completed. We discussed this with the manager who explained their learning would support them to make improvements as they had increased their knowledge of the MCA.

Staff we spoke with did not demonstrate they understood the principles of the Act. For example, when we asked staff about the principles one said, "It's about inclusion. If you have 20 residents in a room and two were making a noise you'd take them out." Another said, "It's about treating people nicely." Despite this people told us staff offered them choices and we observed staff sought consent before they provided people with assistance.

Staff spoke positively about the on-going training they received which they said enabled them to update and further develop their knowledge and skills. One said, "The training is good. We get a booklet and work through it. I prefer that to doing it on a computer." However, the concerns we identified relating to poor infection control, lack of MCA understanding and unsafe moving and handling of people demonstrated staff did not have the requires skills to carry out their roles effectively. This meant we were not assured staff had the knowledge they needed to deliver safe and effective care. We discussed staff training with the manager. They acknowledged that improvement was required in this area. They also explained they were in the process of arranging a variety of training courses including end of life care and dementia awareness by the

end of 2018. At the time of our visits dates for this training had not yet been arranged.

Records we reviewed assured us staff had completed an induction when they had first started working at the home. A system was in place to ensure that staff new to care completed the Care Certificate during their induction period. Records showed us one staff member had completed this at the time of our visits. The Care Certificate is a nationally recognised set of standards for those working in the care sector.

People provided positive feedback about the food provided at the home. One person told us, "Food's nice. I lost my appetite but since I came here it's back." Another said, "I like the dinners." Facilities were available for people to make themselves drinks and we saw some people did this throughout the day. Despite this we saw the lunchtime experience on the first day of our visits was not positive for some people because they felt uncomfortable sitting in the new dining room chairs. One person said, "These chairs are really uncomfortable." Another commented, "This chair is absolutely awful, it's too hard." In response to these comments staff provided people with cushions to sit on to improve their comfort. During our second visit people told us they had 'got used to the chairs' and they did feel comfortable sitting in them.

We were informed no one was at risk of losing weight. The manager was aware of the action they needed to take if weight loss was identified. For example, contacting the person's GP to make a referral to a dietician to support the person. However, some staff members responsible for preparing people's meals did not know how to prepare specialised diets such as fortified foods. We discussed this with the manager who told us all staff members had been booked onto a nutrition training course which was due to take place shortly after our first visit. During our second visit this training was in the process of being completed.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in November 2016 'caring was rated as 'good' but we found one instance where people's privacy and dignity was not maintained. This was because we saw a staff member applied cream to a person's skin in a communal area and the person was not asked if they would like this to take place in a private area. The previous registered manager had assured us action would be taken to address this.

During this inspection we found there continued to be occasions where people's privacy and dignity was not maintained. For example, on two separate occasions we heard the manager and a staff member discussing people's sensitive and confidential information in a communal area and these conversations were overheard by others. On both occasions we had to intervene to stop the conversations. This meant the provider's value to preserve and maintain people's dignity continued not to be achieved because people were not treated with dignity and respect. We discussed this with the manager and staff member. They both acknowledged that their conversations should have taken place in a private area. They assured us this would not happen again.

On another occasion we heard a person say to a staff member as they entered a toilet, "It's freezing in here." The staff member replied, "It's always cold in here." We spoke with the staff member in the corridor by the toilet and asked them if there was a radiator in the toilet. The staff member said, "I don't know." They then without knocking opened the toilet door to look inside. We saw the person was sitting on the toilet. We had to ask the staff member to close the door to maintain the person's privacy and dignity. The staff member then apologised to the person.

We saw one person's oral hygiene routine was written on a notice board in the dining room which meant their personal information was viewed by others. We spoke with a staff member about this. They explained they hadn't noticed the information and they removed it from the notice board on our request.

Staff did not demonstrate they understood the principles and importance of promoting equality and human rights as part of a caring approach. This was despite the training records we looked at confirming staff had completed the training. For example, when we discussed this with staff members one told us, "I think it means ….treating everyone the same." Another said, "Treating people nicely." We were concerned that this lack of understanding meant people's diverse needs might not be recognised and respected. We discussed this with the manager who told us they had no future plans to make improvements in this area to benefit people.

This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect

Most people spoke positively about the staff who provided their care. One person commented, "I don't mind the staff they are okay here." Another said, "They are alright." We saw staff and some people had formed caring relationships. For example, one person was worried and upset because their relation was in hospital. We saw a staff member offered the person reassurance and gave them a hug. The person responded well to

this and said, "Thank you that's made me feel better."

Staff told us they wanted to provide a caring service and they enjoyed spending time with the people they cared for. We saw they were mostly caring in their approach but the lack of staff, and the additional duties they undertook meant they had little time to spend with people. For example, we saw most interactions with people were focussed on completing a care task.

People told us there were no restrictions on visiting times and their family and friends could visit whenever they wanted to. One person explained staff would help them to use the telephone to call and speak to their relation whenever they asked.

Staff told us how they supported people to be as independent as they wished to be when supporting them with care. One staff member said, "We need to be patient with (person) as with encouragement and patience they can wash their own hands and face." We saw on occasion's staff gently reminded people to use their walking frames and hold onto hand rails whilst they walked around the home.

Inadequate

Is the service responsive?

Our findings

At our last inspection in November 2016 we rated 'responsive' as 'requires improvement'. This was because people did not always receive care that met their needs and preferences. Access to social activities in accordance with people's interests were limited. At this inspection action had not been taken to make improvements.

We saw staff tried to be responsive to people's needs. However, assistance was not always provided at the time people required because staff were not always available. For example, during the morning of our first visit we saw one person approached a staff member and asked them to retune one of the stations on their television because they wanted to watch it. The staff member replied, "When I get a minute I'm very busy." We heard the person make the same request to the manager on three separate occasions throughout the day. At 5.30pm the person's request had still not been responded to. We raised this with the manager and asked them to ensure immediate action was taken.

One person told us during our first visit they would like to visit the barbers, for a shave, as this was something they enjoyed doing. However, they told us they had not had the opportunity to do this since they had moved into the home. Staff knew this is what the person enjoyed. We asked if this could be arranged and a staff member replied, "I wouldn't know where to start to find one." We bought this to the attention of the manager who assured us they would arrange for the person to visit he barbers in- line with their wishes. During our second visit the home manager told us they had offered to take the person to the barbers but they had declined. However, when we asked the person about this they said, "No one has asked me."

Assessment of people's needs had been completed before people moved in to the home. However, we saw some important information had not been gathered during the process to ensure people's needs could be met. For example, two assessments we looked at during our first visit did not include the person's cultural or religious need and preferences. We discussed this with the manager and they explained they had asked people the questions but they had not written their answers down. The manager was unable to explain why they had not done this. They acknowledged their pre assessment process required improvement. They told us during our first visit they would make these improvements before any future assessments took place. During our second visit we looked at a competed pre assessment for a person who had moved into the home on 21 February 2018. Despite changes being made to improve the pre assessment paperwork the assessment had not included the person's cultural or religious needs.

People told us they had not had opportunities to participate in planning and reviewing their care. One person said, "What's a care plan? I don't know about that. No one asked me anything." Another said, "I don't think I've been asked about that kind of thing." We discussed this with the manager who assured us people had been involved and they would improve the way this was reflected in people's care records following our visit. During our second visit we looked at the care plan for the person who had moved into the home on 21 February 2018 to check improvements had been made. We found it was not clear the person had been involved in making decisions about their care.

We reviewed five people's care plans. We found care plans did not contain the level of detail staff needed to provide care and support in line with people's needs and preferences. One person told us they had not been asked how they liked to spend their time or what was important to them. One person needed their drinks to be provided in a spouted beaker because they could not drink out of a cup but this information was not recorded.

Some care plans did not contain accurate up to date information. This meant we were not assured people received consistent care which met their needs and preferences. For example, one person told us they liked to spend their time in the lounge with other people. However, their care plan advised they liked to spend most of their time alone in their bedroom. Another person's care plan informed us they enjoyed it when other people visited them in their bedroom. However, the person explained they did not like it when this happened.

Staff told us they tried to read people's care plans but they did not always have time to do this. One staff member said, "We don't get time to read any plans." Another said, "No, the manager deals with all that." Despite this they assured us they would report any changes in people's health or anything that could affect their wellbeing to the manager. Despite omissions in care records staff demonstrated they knew some people's preferences. For example, they knew one person's favourite drink was coffee and they liked to wear socks instead of shoes. The manager was responsible for completing and reviewing people's care records but our discussions with them did not assure us they knew people well. For example, they told us all people who lived at the home walked around independently and this was not the case.

Records showed the provider was not working in line with recommendations made by The Department of Health's end of life care strategy because we found people's care plans did not contain their wishes for end of life care arrangements. This meant there was a risk the person's end of life wishes would not be respected. We discussed this with the manager who assured us they would discuss this with people and then add the information to their care plans by 23 February 2018. During our second visit we found this had not happened because people's care plans had not been updated to reflect their wishes.

During our last visit people told us there were limited social activities that took place within the home. At that inspection we were advised the provider had been approached by the previous registered manager in regards to providing more resources to improve activities. At this inspection we found improvements had not been made because people told us they were not satisfied with the social activities available to occupy their time. One person told us, "I do nothing. It drives me up the wall." Another told us, "I would like to go out somewhere to meet people. People my own age with the same interests"

During our first visit we saw people watched TV and listened to music in the lounge. However, these were not in accordance with people's interests and preferences because we heard one person ask a staff member to turn the music off because it was too loud and they didn't like it. During our second visit we saw no activities took place. Some people lived with dementia and we did not see any resources which would provide good dementia care, such as reminiscence books, or activities to stimulate people's interests or senses and give people a sense of purpose.

We asked staff about social activities and one told us, "We don't have time to do activities." Another said, "There is only two of us [Staff] so we can't just take residents out. I came in on my day off to take one person Christmas shopping." We discussed this with the manager during our first visit and asked them for a response. They explained when they had started working at the home they had asked the provider for an additional staff member to provide activities but their request had not been responded to at the time of our visit. They had not taken any action to follow this up. During our second visit the manager told us they had

begun to make improvements such as, asking people what social activities they would like to happen at the home.

People lived in an environment that was not always suitable for their needs. For example, we saw at lunchtime one person was not asked if they wanted to sit in a dining room chair to eat their meal. Staff confirmed this was because the person could not choose to sit in a dining room chair because the piece of equipment they needed to use to transfer safely did not fit into the dining room. We saw another person remained in the lounge and ate their meal in isolation at lunchtime. The person commented, "They all leave me." This was also because the specialist chair they needed to sit in was too big to be accommodated in the communal dining room.

There was no information available at the time of our visit to show the provider or manager worked in partnership with the local community to promote the service and enhance people's lives. The manager told us they had no current plans to develop any links with the local community.

This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care

Staff told us they attended a 'handover' meeting at the start of their shift and they explained this meant they received important information about each person that lived in the home such as, how the person was feeling. A communication book was also in use and we saw staff used this to share information such as people's planned appointments.

The manager was not familiar with the 'Accessible Information Standard' [AIS]. The AIS aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand and any communication support they need. Despite this people's communication needs had been assessed and guidance for staff was in place to inform them how to support people to achieve their desired outcomes. For example, one person's care plan detailed they could make daily choices. Staff needed to explain clearly what they were asking and give the person time to answer their questions. We saw staff did this.

People told us they were confident staff would deal with any complaints or concerns they had. The provider had a complaints policy that included information about how to make a complaint and what people could expect if they raised a concern. The policy was displayed within the hallway of the home. Records we looked at showed three complaints had been received and resolved to the complainant's satisfaction since our last inspection.

Inadequate

Is the service well-led?

Our findings

This key question was rated as 'requires improvement' at our last inspection. This was because we found processes and systems were not fully effective in ensuring the quality of service was always maintained. At this inspection we found improvements had not been made.

Since our last inspection there had been a change of management at the home. The previous registered manager had left their employment in August 2017. A new manager had been in post since October 2017. They had begun their application process with CQC to become the 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 2008 and associated Regulations about how the service is run.

We found systems and processes to monitor assess and improve the quality and safety of the service remained ineffective. For example, risks in relation to the fire safety of the home had not been mitigated which placed people at significant risk. Health and safety checks had not identified some risks we found during our inspection. This meant we could not be assured risk was being managed to keep people safe.

The provider had not ensured the home environment was adapted and designed to support the needs of some people. This was because some people could not access all areas of their home such as the dining room. Some of the décor required improvements.

Risks related to people's care and support needs were not effectively managed. We found some important information was not recorded and some information was incorrect which meant staff were not supported to provide safe, consistent care to people.

The manager told us since taking up their post they had received some support from the provider. However, this support had not included meetings to discuss their performance or the provider's expectations of them. The manager told us the provider visited the home weekly but they did not complete any checks to ensure the home was being run in line with their aims for the service. This meant we could not be sure how the provider assured themselves the home was being effectively managed.

It was not evident how people were involved in making decisions about their care. The arrangements in place to check the quality of people's care plans were not effective. We found the manager and provider continued not to work within the requirements of the MCA. This meant people's rights were not always protected.

The provider had not ensured staff had completed all the training they needed to be effective in their roles. People felt more staff were needed to meet their needs and staff told us they would feel better supported by the provider if more staff were on duty. The system the provider used to assess how many staff were needed to support people safely was not effective. This had resulted in there not being enough staff available to

provide the care and support people needed.

The providers' PIR completed in December 2017 by the manager stated, 'I will attend the Coventry Network Meetings which will keep me up to date with the current legislation and good practice recommendations.' However at the time of our visit this had not happened because the manager told us other work commitments had needed to take priority. This meant we were not confident the manager had sufficient knowledge of best practice and legislation to continually improve the service provided. However, following our first visit we were made aware that the manager had attended a network meeting in March 2018.

Some people told us they did not know who the manager of the home was. One person said, "No, I don't know the manager." Another commented, "I've seen the new manager. I don't know their name." Despite this the manager told us they encouraged people to put forward their suggestions and views about the running of their home. In November 2017 records showed a meeting had taken place but we found the minutes from the meeting had not included people's views as the meeting had been held for the new manger to introduce themselves. A further meeting had been planned to take place in January 2018. However, this had not happened because the manager told us they hadn't had time to arrange it. The manager told us they would take action to ensure meetings did take place in the future. During our second visit we saw the dates of planned meetings was on display in the dining room.

At our previous inspection the provider's systems and processes to seek feedback from people about the service they received and to drive forward improvements were flawed. This was because staff had completed quality surveys on behalf of people who lived at the home. This meant the provider could not demonstrate the views expressed were a true reflection of people's opinions. The previous registered manager assured us the process would be improved. However, at this inspection we identified lessons had not been learned and improvements to the process had not been made. We saw the latest quality survey dated December 2017 had, again, been completed by staff on people's behalf; this was despite some people telling us they could complete them for themselves.

The Langleys is registered to provide accommodation and personal care to older people. However, during our visits one younger adult with a learning disability lived at the home. The person told us they did not like living at The Langleys because there was not enough for them to do to occupy their time. This meant that the care and support provided to people did not correspond with the provider's statement of purpose. A statement of purpose includes the aims and objectives of the service provider in carrying on the regulated activity they are registered for. The provider acknowledged that the person should not have been placed at the home. We discussed this person with the manager who told us they had accepted them as an emergency placement in November 2017. Despite this no action had been taken since their admission to support the person to find a home that could meet their needs. Following our first visit we shared this information with the local authority that funded the person's care and asked them to take action to support the person. During our second visit records showed and the person confirmed they had been visited by their social worker and their advocate to support them to decide where they would like to live in the future.

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

Staff we spoke with provided positive feedback about the manager. One said, "You can talk to the manager." Another commented, "If there is a problem you can go and ask the manager." They told us the manager and the provider was approachable and confirmed they had opportunities to attend staff meetings.

Staff told us they were supported in their roles through individual support meetings (supervision) with the

manager. This meant staff were given opportunities talk about their role and raise any concerns that they had. One staff member told us, "Yes, I meet with the manager. We talk about all sorts of things. It's ok."

It is a legal requirement for the provider to display their ratings so that people are able to see these. The provider did not have a website but we checked and found their latest rating was displayed within the home.

In response to the concerns identified during the inspection, the provider has taken the decision not to admit further people into the home until improvements are made. Local Authority commissioners are supporting the provider to bring about improvements required.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs or reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with dignity an respect.

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 for service users. Steps were not taken to do what is reasonably practicable to mitigate risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively. Risks were not identified and monitored. Accurate and contemporaneous records were not held in respect of each service user. Systems to gather peoples feedback were not effective.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Sufficient numbers of suitably trained staff were not always available to support people's care needs.