Michael C S Kainth

Langdale Residential Home

Inspection report

23 Bierley Lane
Bierley
Bradford
West Yorkshire
BD4 6AB

Tel: 01274682164

Date of inspection visit:
29 September 2021

Date of publication:
08 November 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Langdale Residential Home is a residential care home providing personal care for people aged 65 and over. The care home accommodates 19 people in one adapted building. At the time of the inspection there were 17 people living at the home.

People's experience of using this service and what we found
Some improvements were needed to make sure people were safe. Risk assessments needed to be in place to make sure all risks to people's health and safety were managed.

We were not assured that systems were in place and guidance being followed to minimise the risk of spread of infection within the home.

Improvements were needed to make sure medicines were stored safely.

We have made a recommendation the provider puts a system in place to make sure medicines are stored at temperatures recommended by the manufacturer.

Recruitment was managed safely. The staff team were consistent and experienced and had the skills to support people safely. Some people told us they thought more staff were needed and rotas showed days when only three staff were on duty.

We have made a recommendation the provider reviews staffing arrangements to make sure they are sufficient to meet people's needs.

The home needed some refurbishment and the garden needed to be cleared of rubbish to provide a safe space for people to enjoy.

People who used the service, relatives and staff provided good feedback about their experience. People said they felt safe and staff were caring and kind.

Systems to monitor and check the service were in place but these needed to be more thorough to identify the issues we highlighted during this inspection.

There was a lack of oversight of the quality and safety of the service by the provider. We have made a recommendation they establish systems and processes to ensure they have effective and regular oversight of the quality and safety of the service.

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

Rating at last inspection
The last rating for this service was good (published 18 November 2017).

Why we inspected
This was a planned inspection based on the previous rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this report. You can see what action we have asked the provider to take at the end of this full report.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches of regulations 12 (Safe Care and Treatment) in relation to infection prevention and control and 17 (Good Governance).

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Langdale Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by one inspector 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.

Service and service type
Langdale Residential Home 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 service had a manager registered with the Care Quality Commission at the time of this inspection. Registered managers along with the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The site visit to the care home was unannounced. Inspection activity started on 23 September 2021 and finished on 11 October 2021. We visited the care home on 29 September 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, Healthwatch and professionals who work with the service. Healthwatch is an

independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with three people who were using the service and six relatives of people who used the service about their experience of the care provided. We spoke with seven members of staff including the registered manager, deputy manager, the cook, a cleaner and three care workers. Discussions with people who used the service were face to face and discussions with relatives were via telephone calls.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. This included training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

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

Preventing and controlling infection

● We were not assured that the provider was preventing visitors from catching and spreading infections.
A system was in place for visitors which included a separate entrance where they could put on and take off PPE safely. However, when one of the inspection team arrived at the service, they were not asked for evidence of a negative lateral flow test, were not asked to put a face mask on and were not directed to hand sanitizer or handwashing facilities.

● We were not assured that the provider was using PPE effectively and safely.
Not all staff were wearing face coverings correctly. Some were constantly slipping down which meant staff were touching them to put back in place, some were not fitted to the face and one member of staff was wearing a thin fabric mask. One member of staff came into the home without a mask. Several members of staff were wearing jewellery and wrist watches.

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.
We saw two dirty and very dusty wall mounted fans which had been brought from another of the provider's services. A toothbrush left on the washbasin in a shared room was not name marked and the registered manager said they would not know which of the people who occupied the room owned the toothbrush. Both issues presented a risk of spread of infection.
Some carpets needed replacing due to staining and rubbish piled in the garden needed to be cleared to make the area safe for people to use.

● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were somewhat assured that the provider's infection prevention and control policy was up to date.
The infection prevention and control policy had been updated to include measures for managing COVID-19. However, the policy did not include direction for staff in relation to being bare below elbows and not wearing jewellery. The policy was unclear in relation to mask wearing stating 'Use disposable face clothes at all times', but did not specify the masks must be fluid resistant or include best practice guidance in making sure they were correctly fitted.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate infection prevention and control measures were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was taking all necessary precautions to meet shielding and social distancing rules.

The deputy manager told us about the difficulties they had encountered during an outbreak of COVID-19 in trying to support people living with dementia to isolate. They had sought, and followed, advice from the local authority COVID team in relation to this.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.

We have also signposted the provider to resources to develop their approach.

Using medicines safely
● Medicines were stored in a small unventilated room which felt very warm. There was no process in place for checking the temperature of the room to make sure medicines were stored at the correct temperature. The deputy manager told us they used the bath thermometer when they checked the temperature of the room but there were no records to support this and a thermometer could not be located.
● Monthly audits of medicine management were completed, and actions taken where issues were identified. However, audits had not identified the failure to monitor the temperature of medicines storage.

We recommend the provider puts a system in place to make sure medicines are stored at temperatures recommended by the manufacturer.

● Staff had completed medicines training and had their competency assessed to make sure they had the necessary skills and knowledge.

Staffing and recruitment
● People's dependency levels were not used to calculate staffing levels.
● There were not always enough staff available to meet people's needs safely. Some of the people living at the home required two staff to support them and rotas showed occasions when only three staff, including the senior in charge, were on duty.
● We did not see evidence of people's physical care needs not being met, however, on the day of the inspection the activities organiser was on leave and we saw people sitting in lounges for long periods of time without being offered or engaging in any meaningful activity other than the radios playing through the televisions in both rooms.
● One person who lived at the home said, "They could do with a few more staff, they are very busy." Another person said staff would chat with them when they weren't too busy.

We recommend the provider reviews staffing arrangements to make sure they are sufficient to meet people's needs.

● Recruitment processes were safe with all required checks completed before new staff started employment.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe at the service. Staff had received safeguarding training and knew what to do if they thought somebody was at risk.

● Safeguarding referrals had been made to the local authority as needed.

● Safeguarding policies and procedures were in place and safeguarding events were analysed to help identify any common themes.

Assessing risk, safety monitoring and management

● Risks to people's health and well-being had been assessed and risk assessments developed. However, one person's care records showed they had lost almost 9kg in the previous two months. There was no risk assessment or care plan in place relating to this.

● Risk assessments were in place in relation to COVID -19 but lacked detail about the level of precautions needed in different situations, for example, during an outbreak.

● Personal emergency evacuation plans (PEEPs) were in place and easily accessible in the case of emergency.

● Systems were in place to ensure environmental safety.

Learning lessons when things go wrong

● The registered manager used outcomes of audits and feedback to assess where changes or improvements were needed

Requires Improvement

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The registered manager had been in post for many years. They were supported by a deputy manager and senior care staff.
- There was a system of auditing quality and safety in the service with audits of various areas completed by the registered manager and deputy manager at varying intervals. However, audits had not identified and managed issues in relation to infection control.
- Audits had not identified the lack of a dependency tool to support the provider in providoing appropriate staffing arrangements.
- There was no evidence of any oversight or audits completed by the provider. The registered manager said the provider responded to requests but had not completed any auditing for several years.

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

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

- Most people we spoke with were complimentary of the registered manager. One said, "I know the manager, she's very nice. She mucks in." One person's relative told us they didn't know the manager and wouldn't know who to go to if they had concerns about the service. However, they added that they wouldn't change anything about the service their relative received.
- The registered manager sought feedback about the service from people and their relatives through quality monitoring surveys. Results of the surveys were shared with people in a 'You said, we did' format.

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

- The registered manager understood their responsibilities in reporting events that happened in the service. Reports to safeguarding, local authority and CQC were made as needed.

Continuous learning and improving care

- Systems were in place to review accidents, incidents and complaints. Issues identified were analysed in

order to identify what could be done to mitigate the risk of reoccurrence.

Working in partnership with others

- Staff worked in partnership with other health and social care professionals.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to demonstrate infection prevention and control measures were effectively managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not complete audits of the quality and safety of the service.