

Langford Park Ltd

Langford Park

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection was unannounced and took place on 6 and 7 June 2017. The provider was on leave during the inspection, so we met with them on 23 June 2017.

The previous inspection of the home was carried out on 18 and 22 February 2016. At that inspection the service was rated as 'requires improvement' in all domains and 'requires improvement' overall. We found no breaches of regulation. At this comprehensive inspection in June 2017 we found significant improvements had been made, however additional areas of concern and breaches of regulation meant further improvements were needed to ensure people's safety. The service has therefore again been rated 'requires improvement' overall.

Langford Park is registered to provide accommodation, nursing and personal care support for up to 34 older people, people living with a dementia and younger people with a physical disability. At the time of this inspection there were 29 people living there, with one new person moving in on the day of the inspection. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When we last inspected in February 2016, a whole service multiagency safeguarding process was underway to protect people's safety and well-being. The local authority safeguarding team, the commissioning team and the Quality Assurance and Improvement Team (known as QAIT) had been closely monitoring the home with regular visits, and providing training and support to help the provider and management team establish effective care and management systems. While we found significant improvements in the management and quality of the service, it was too soon at this stage to determine whether they would be sustained, and some improvements were yet to be implemented. This comprehensive inspection in June 2017 was carried out to check whether the improvements made had been sustained, and the service was now providing safe and effective care to people.

At this inspection we found that although there were systems in place to ensure people received their medicines safely, they were not always effective. For example, the member of staff doing the drugs round was distracted by the need to answer the door to visitors and provide support to other members of staff, which meant medication was administered late to people. Guidance had not been sought from the pharmacist on the safest method for administering covert medicines, in line with the service's covert medication policy. Medication requiring disposal was observed on top of a cupboard in the nurses' office, when regulations state that medication requiring disposal should be stored in a tamper proof container and locked away. One person had three opened tubes of the same cream in use, one of which had no recorded expiry date.

During the inspection we found that the management of clinical waste was not safe, which put people at risk

due to the potential for the spread of infection. Two open bags of waste, including used disposable gloves, were left on the floor in the laundry.

At the last inspection in February 2016 we found that improvements were needed in relation to the assessment of risk, particularly related to falls and accident and incidents. At this inspection we saw there were now effective systems in place to assess and minimise risks, supported by a new computer based care planning system. However, further improvements were needed to ensure staff had the information they needed to keep people safe, specifically related to the safe use of pressure relieving mattresses.

At the last inspection the provider did not have adequate systems in place to monitor and review the quality of care and ensure the service continued to meet people's needs effectively. At this inspection we found a comprehensive system of audits was now in place. However, further improvement was required to ensure people's safety with regard to medicines administration, infection control and the use of pressure relieving mattresses. Following the inspection the provider sent us an updated service improvement plan which showed that these issues were being addressed.

People were supported to maintain good health and had access to healthcare services; however staff did not consistently follow guidance from healthcare professionals. This related to people being supported to follow exercise programmes and the provision and use of recommended equipment such as pressure cushions. We have made a recommendation that the registered manager and provider take further steps to ensure they work more effectively with health professionals, seeking support and further training from an appropriate source.

People and health professionals expressed concern about staffing levels and told us staff were, "rushed off their feet". The registered manager acknowledged that recruitment and retention of staff had been an issue, but provided reassurance that there were enough staff deployed to meet people's complex needs and to care for them safely. There had been a successful recruitment drive, and they told us, "We are almost fully staffed now, and have an excess of nurses". They planned to "over employ" saying, "I'd rather over employ than be in a situation where we are left in the lurch".

The home was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. They, along with the provider were committed to the improvement and development of the service and had commissioned an external consultant to mentor them and turn Langford Park into a home which provided "outstanding care for residents" where people want to work". There had been significant changes across the service which had had a positive impact. A health professional told us, "Our team feel privileged to have worked with Langford Park over the last 18 months. We were part of the original safeguarding enquiry and as a result we have been able to experience the improvements made first hand".

When we last inspected in February 2016 we found that staff had not been receiving regular individual support and supervision. At this inspection we found staff now received regular individual supervision and an annual appraisal, and they told us they felt well supported.

At the last inspection concerns were expressed that, although the physical care was good, staff weren't always as thoughtful as they could be, for example leaving people without their hearing aids and glasses. At this inspection we found there had been significant improvements. A new 'values framework', had been developed which encouraged staff to deliver 'outstanding care' with kindness and compassion. People and their relatives told us staff were caring and thoughtful. One person said, "They are so obliging...I am so impressed with this place, and they all seem to go that extra mile".

When we last inspected in February 2016 people and their relatives told us there had been a large turnover of staff, which had made it difficult for them to build relationships with the staff who supported them. At this inspection we found the service had been proactive in helping people and staff build relationships, for example by displaying staff photographs in the main entrance so that people would know who they were and ensuring people were supported by a consistent staff team.

At the last inspection we found care plans did not contain information about people's history and background and people did not always contribute to their development. In addition people were not always consulted about their end of life wishes, and they were not documented in care plans. At this inspection we found people, and their relatives where appropriate, had been fully involved in the development of their care plans and consulted about their end of life wishes. This meant staff and professionals had the information they needed to provide personalised care. They would know what the person's wishes were for their future care and final days, and could ensure they were respected.

When we inspected in February 2016 we found that there was one activities organiser with limited time available to assess and meet the diverse social care needs of everybody at the home. At this inspection we found there were now two activities co-ordinators in post who supported people to engage in a wide range of activities according to their needs and interests.

A comprehensive induction and training programme meant staff were knowledgeable about their roles and responsibilities, and people's individual needs. This included specialist training from external health professionals.

Policies and procedures ensured people were protected from the risk of abuse and avoidable harm. Staff told us they had regular safeguarding training, and they were confident they knew how to recognise and report potential abuse. Staff were recruited carefully and appropriate checks had been completed to ensure they were safe to work with vulnerable people.

People had sufficient to eat and drink and received a balanced diet, and care plans guided staff to provide the support they needed.

Staff promoted people's independence and treated them with dignity and respect. People were supported to make choices about their day to day lives, for example how they wanted their care to be provided and how they wanted to spend their time. The service ensured people and their advocates where appropriate, were fully consulted and involved in all decisions about their lives and support. This meant people's legal rights were protected.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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 

Some aspects of the service were not safe.

Systems to ensure people received their medicines safely were not always safe.

People were at risk due to inadequate systems for maintaining infection control and hygiene.

Staff did not always have the information and guidance they needed to keep people safe.

People were protected from the risk of abuse through the provision of policies, procedures and staff training.

Is the service effective?

Good 

The service was effective.

The service acted in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care or treatment.

People received effective care and support from staff with the experience, skills and knowledge to meet their needs.

People were effectively supported with nutrition and hydration.

People were supported to maintain their health and access healthcare services, although guidance was not consistently followed.

Is the service caring?

Good 

The service was caring.

People were treated with kindness and dignity.

Staff were committed to promoting people's independence and supporting them to make choices.

The service provided effective care and support to people at the

end of their lives.

Is the service responsive?

Good ●

The service was responsive.

Care plans contained the information staff needed to provide personalised care.

People were able to take part in a wide range of social activities.

There was an effective complaints process which people were supported to use if necessary.

Is the service well-led?

Requires Improvement ●

One aspect of the service was not well led.

Systems to monitor the quality of the service were not fully effective.

The manager and providers were committed to developing and improving the service for the benefit of people and staff working there.

The service had a strong value base, and promoted an open and caring culture centred on people's individual needs.

People were supported by a motivated and caring team of management and staff.

Langford Park

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 6 June 2017, 7 June 2017 and 23 June 2017 and was unannounced. It was carried out by one inspector, a specialist advisor with expertise in nursing and dementia care 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.

Prior to the inspection we reviewed information we held about the service, including the Provider Information Return (PIR), notifications, previous inspection reports, safeguarding and quality assurance reports and feedback from Devon County Council commissioners and community health professionals. A notification is information about specific events, which the service is required to send us by law. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at a range of records related to the running of the service. These included staff rotas, supervision and training records, medicine records and quality monitoring audits.

We looked at the care provided to people, observing how they were supported, looking at 10 care records and speaking with eleven people to help us understand their experiences. We spoke with seven relatives and fourteen staff including the registered manager, deputy manager, provider, activities organiser and chef. We also spoke with three health and social care professionals who supported people at Langford Park and delivered training to staff.

Is the service safe?

Our findings

At the last inspection In February 2016 we found some aspects of the service were not safe. At this inspection in June 2017 we found significant improvements had been made in the areas identified, however we found additional areas of concern which meant further improvements were needed to ensure people's safety.

Although there were systems in place to ensure people received their medicines safely, they were not always effective. For example, a member of staff was wearing a tabard to indicate they were doing the drugs round and should not be interrupted. This was to allow them to focus on the task and give people their medicines correctly and safely. However, during the drugs round the member of staff was distracted by the need to answer the door to visitors and provide support to other members of staff. This meant that medication was being administered at 10:55am to people who were prescribed medication to be given at 8am. People told us their medication often arrived later than it should. One person had to take their tablets with food, so if the tablets hadn't arrived, the food had to wait.

One person had their medicines administered covertly. A mental capacity assessment and best interest process had taken place in line with current legislation and guidance, which indicated the person did not have capacity related to their understanding of their need for medicines, and it was in their best interests to have their medicines given covertly. However guidance had not been sought from the pharmacist on the safest method for administering the medicines, in line with the services' covert medication policy.

Medication requiring disposal was observed on top of a cupboard in the nurses' office, when regulations state that medication requiring disposal should to be stored in a tamper proof container and locked away. A member of staff told us, "It's not been entered yet on the system; its then put in the medication bin and collected. It should be in the medicine room, I haven't had a chance yet".

One person had three opened tubes of the same cream in use, one of which had no recorded expiry date. This meant it was difficult to ascertain whether or not this person has been receiving their regular twice daily application of cream and whether the cream being used was still in date.

During the inspection we found that the management of clinical waste was not safe, which put people at risk due to the potential for the spread of infection. Two open bags of waste, including used disposable gloves, were left on the floor in the laundry rather than safely contained in a clinical waste bin.

At the last inspection in February 2016 we found improvements were needed in the assessment and management of risk to ensure that people received safe care. At this inspection in June 2017 we found that while improvements had been made, further improvements were needed to ensure staff had the information they needed to keep people safe. For example, a person at risk of skin breakdown, who had just moved in to Langford Park, was observed to be lying on a deflated mattress. Staff were not aware that the mattress was an air mattress and attached to a motor. The instruction manual was found to inform staff of its correct usage, and a health professional visited to check that all the appropriate equipment was in situ and to offer advice and support. In addition, although mattress functions were checked and recorded daily,

another person's mattress was not at the correct setting for the person's weight.

These issues constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Following the inspection the provider sent us an action plan to advise us of actions they had taken to mitigate the risks we had identified. Competency assessments for all staff had been planned in the administration of medicines. Staff had been reminded of the importance of not being distracted when administering medicines and the tabard should only be worn when they were doing this task. A full audit of all medication trolleys would be undertaken and any undated opened creams removed. A member of staff would be nominated to audit the trolleys on a monthly basis. In addition the registered manager would ensure that advice from a pharmacist was consistently sought regarding the safe administration of covert medicines in line with their policy.

The provider advised us the incident related to infection control had been a 'one off'. They had followed it up with the housekeeping team and emailed them guidance about the correct and safe way to dispose of clinical waste. In addition training in infection control would be reviewed and staff assessed to ensure their competency.

The setting of the mattress was changed immediately when the nurse was made aware. The provider advised us that a task list would now be completed the day before a new admission; to ensure that all the equipment and support the person needed was in place. Mattress settings would be checked daily and audited monthly.

People had access to call bells, and we saw they were in easy reach. However, people told us the response times when they rang their call bell varied, and could be more than 15 minutes. Comments included, "I do wish they would answer the bell more quickly, but they are very busy", "Some days there are not quite enough staff" and, "They could do with more staff as they seem short-handed". We observed during the inspection that care staff were extremely busy and had little interaction with people in the communal area unless they were assisting them with a task. Quality Assurance records from three months prior to the inspection had identified that staffing levels were a concern, stating, "There is an acute need for more staff to be recruited in order to improve care plans, supervision, induction, reduce the agency staff and provide a safe environment for the residents". This was confirmed by a health professional who told us, "It's improved in some aspects, but they always seem short staffed". They added, "Staff are caring. They do their best, but they are rushed off their feet. It makes it hard for them to do everything. It's hard for us to find a member of staff who will spend time with us while we are there".

The registered manager acknowledged that recruitment and retention of staff had been an issue, but provided reassurance that there were enough staff to meet people's needs safely and effectively. They used a tool to calculate the number of staff needed to meet the individual needs of the people at the service and used agency staff to maintain staffing levels if necessary. There was a supernumerary nurse and team leader on every shift, as well as the deputy manager. This meant there were always staff to cover if there was any shortfall, for example due to last minute sickness. The registered manager told us they were working towards having a permanent and consistent staff team, without the need for agency staff. They said, "We had a huge recruitment drive, and we increased wages. We are almost fully staffed now, and have an excess of nurses". There were four team leaders in post, and another being recruited; five nurses and another due to start; 17 care staff with five waiting to start, plus two activities co-ordinators, the registered manager and deputy manager, as well as domestic and catering staff. The registered manager told us they planned to "over employ" saying, "I'd rather over employ than be in a situation where we are left in the lurch".

The service protected people from the risk of abuse through the provision of policies, procedures and staff training. People told us they felt safe. Comments included; "Oh yes - I feel very safe here" and, "I feel safe and secure here and I rely on the staff". The service had worked closely with the local authority safeguarding team and commissioners to investigate safeguarding concerns and take action to keep people safe. The registered manager told us that following the local authority safeguarding process they met with every member of staff to ask them if they would report any concerns they might have about the practice of staff colleagues. They told us, "50 per cent said no, and they no longer work for the service". Current staff told us they wouldn't hesitate to use the services whistleblowing policy. They knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. One member of staff said, "I feel confident enough to go to the registered manager".

Risks of abuse to people were minimised because the registered manager ensured all new staff were thoroughly checked to make sure they were suitable to work at the home. Staff recruitment records showed appropriate checks were undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all records. The DBS checks people's criminal history and their suitability to work with vulnerable people.

Langford Park had introduced a new computer based care planning system, which had been in place since January 2017. Staff accessed the system using handheld computers and told us they felt confident and competent to use it. Agency staff received training in how to use it as part of a basic induction. The registered manager told us, "All staff can access the system. Consistency isn't an issue. The more you use the system the easier it gets". The system ensured information from the person's initial assessment and current assessment of risk was fed through to the person's care plan. This meant staff could easily access the information and guidance they needed to provide safe and effective care. An 'ad hoc' facility allowed staff to record any changes in circumstances or risk. The information was automatically entered into the hand-over notes and shared with staff as they came on shift. This meant they were able to respond promptly and consistently to any changes in people's needs or vulnerability.

We found that risk assessments were clearly documented on the system, particularly regarding pressure area care, nutrition, falls and moving and handling. They contained clear guidance for staff about the action required to minimise the risk and keep people safe. For example one person had been assessed as being at very high risk of skin breakdown. This person had an air mattress on their bed and a high risk pressure cushion in their chair. A body map detailing areas of soreness had been completed and photographs taken. The person required, and was receiving, regular checks and support with repositioning over a 24 hour period. Their nutritional risk had been assessed and closely monitored, and a referral to specialist health care professionals had been made. Interventions and observations were documented as they happened, for example when a person had been repositioned to maintain their skin integrity. A red flag icon on the system indicated if the care was overdue. This meant senior staff and the management team had a clear oversight of what was being completed and when, and could ensure that all care and support was provided safely and effectively.

Staff had a good understanding of the policy and procedures related to accident and incident reporting. Records were clear and showed appropriate actions had been taken. These records were audited by the registered manager in order to identify any causes, wider risks and trends. The provider and registered manager could then take any preventative actions that might be necessary to keep people safe.

There were emergency plans in place so that people would be supported in the event of a fire or other emergency. Each person had a personal emergency evacuation plan (PEEP) to show what support they would need. This meant staff and the emergency services would not easily be able to find information about

the safest way to move people quickly and evacuate them safely. Staff had received training in fire safety, and fire checks and drills were carried out in accordance with fire regulations.

Is the service effective?

Our findings

When we last inspected in February 2016 we found that staff had not been receiving regular individual support and supervision. Formal staff supervision had just been introduced in the form of one to one sessions. At this inspection in June 2017 we found there had been significant improvement. Staff confirmed that they now felt well supported. They received regular individual supervision and an annual appraisal. Issues discussed included their workload, any concerns they might have, or training needs. The PIR stated, "Staff receive regular training and supervisions to ensure their skills and knowledge are up to date. All new staff are supported by a competent staff member until confident and competent to work alone. Staff are encouraged through the supervision process to request any training that they would like to attend that may fall outside of our current training package. All team leaders are attending leadership training to ensure they are supporting other team members effectively".

People received effective care and support from staff with the experience, skills and knowledge to meet their needs. One relative said they were 'delighted' with the care their family member received. They told us they were, "really pleased with their progress. Without a doubt they have improved since being here". Throughout the inspection care staff consistently demonstrated that they had a good understanding of people's individual needs, including nutrition, pressure area care, moving and handling and continence. For example one staff member told us, "We sit and talk with people, encouraging them to take a balanced diet. We check skin integrity every time we carry out personal care. We keep an eye on skin and if we have any concerns we look on the medication system for any prescribed creams and take a photograph and report to the nurse". Another staff member told us, "We encourage regular visits to the toilet and check everyone's catheter regularly".

New staff had a comprehensive induction, which gave them the basic skills they needed to care for people's safely. Recently employed staff told us the induction was good, and they had received the support and training they needed to help them feel confident in their role. The induction programme had been revised and extended since the last inspection in February 2016. The provider told us, "The success of our staff members depends on how good the induction is, and three days wasn't long enough". New staff spent their first week at Langford Park shadowing more experienced staff and being mentored by a team leader. Core training was undertaken, which included learning about Langford Park's 'values' framework and people's individual support needs. The next six months were spent working closely with their mentor, being observed and having their competency and understanding assessed. On successful completion of the induction and probationary period, staff were given a certificate and welcomed to the team by Langford Park's chief executive officer. The provider said the induction meant "...good care is given in line with our values. Staff are competent and confident. Frontline leaders and managers know there is consistency, no matter who is on the floor".

A rolling training programme was in place covering key areas such as moving and handling, safeguarding, nutrition and wound care. Additional specialist training was arranged so that staff could meet people's complex needs. For example, during the inspection we spoke with a respiratory health professional who, at the request of the service, had provided training in the use of oxygen and specialist equipment to support

people's breathing. Another health professional told us, "I have provided a lot of training to the home. Where there have been issues around staff non-attendance, I have observed the management team making real efforts to rectify the situation.

I am always impressed with the staff group that attend training. They are committed and engaged to the education that I deliver. They consistently demonstrate an insight into the needs of their residents."

Staff were aware of their responsibilities under the Mental Capacity Act 2005 (MCA) and how to apply its principles to their practice. The 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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Care plans demonstrated that assessments of people's capacity to consent to their care and treatment had been assessed. Where a person had been assessed as lacking the capacity to consent, staff had involved people's representatives and health and social care professionals to determine whether a decision was in the person's best interests. These included decisions about living at Langford Park, the management of medicines and how their support was provided. This ensured people's legal rights were protected.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). 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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service had referred people for an assessment under DoLS where required.

People's nutrition and hydration needs were assessed to make sure they had sufficient to eat and drink and received a balanced diet in line with their preferences. Food and fluid charts were on the new computer based care planning system, and we observed staff recording the amount of fluid given to people throughout the day. Jugs of fruit squashes were observed in people's rooms, and there was a 'station' in the communal area where people or visitors could make their own drinks, with the support of staff, or independently if they were able. The service catered for people with special dietary needs, for example a diabetic, soft or pureed diet, following guidance from health professionals. The chef told us, "We try and make it as nice as possible, try and make it look appetising". A chart documenting dietary and fluid requirements was also available in the dining area to prompt staff and provide information for agency staff who might not know people's nutritional support needs.

People could choose where they wanted to eat their meals, and food choices were discussed with them each day. Two people told us they weren't so keen on the hot meals, however the chef told us, "We make sure that what the residents want is on the menu, what they like to eat. We go around before lunch. They can ask for anything they would like". The registered manager said, "The kitchen budget has increased. The food is much better". This was confirmed by a relative who told us, "'The food had gone downhill a little while ago but it's good now, especially the Sunday roast dinners". Another relative said, "People enjoy the food. They don't spare anything".

People were supported to maintain good health and had access to healthcare services. Nursing staff told us referrals were made to specialist services when required, including the speech and language therapist (SALT), tissue viability nurses, dieticians, mental health teams, and their involvement was documented in people's records. One health professional told us, "If a patient is struggling they will contact us. They know what to do". Another health professional said the new computer based care planning system made it more difficult for them to look at historical information. They also told us, "Although staff respond to the initial

recommendations, sometimes they are not consistent in their care". This related to people being supported to follow exercise programmes and the provision and use of recommended equipment such as pressure cushions.

We recommend that the registered manager and provider take further steps to ensure they work more effectively with health professionals, seeking support and further training from an appropriate source.

Is the service caring?

Our findings

At the last inspection in February 2016 concerns were expressed that, although the physical care was good, staff weren't always as thoughtful as they could be, for example leaving people without their hearing aids and glasses. At this inspection we found the service had developed a new 'values framework', and incorporated it into staff induction and supervisory systems. It encouraged staff to deliver 'outstanding care' with kindness and compassion. People and their relatives spoke positively about how caring and thoughtful the staff were. Comments included, "They give very, very wonderful care. They are very kind and caring and friendly, they really listen", and, "They are so obliging...I am so impressed with this place, and they all seem to go that extra mile". A newly employed member of staff told us the staff at Langford Park were "more caring than I've seen before. They all collectively want to help". A senior member of staff said, "I like working here, everyone does things properly, they don't skimp on anything. People are treated with respect and dignity; the sheets are laundered to a high standard so that there are no creases or wrinkles to harm people".

When we last inspected in February 2016 people and their relatives told us there had been a large turnover of staff, which had made it difficult for them to build relationships with the staff who supported them. At this inspection, in June 2017, we found there had been significant improvements. Most people knew the names of staff, and a health professional told us, "There are some consistent staff, especially the nurses". The service had been proactive in helping people and staff to build relationships, for example by displaying staff photographs in the main entrance so that people would know who they were. People had a named keyworker, and those with more complex needs had an allocated named nurse, a named shift leader and a named carer to oversee their care. Outside people's rooms (where permission had been given) there was a brief profile of the occupant, to inform staff about the person's interests, preferences and how they liked to be supported.

When we last inspected in February 2016 we found people were not always consulted about their end of life wishes, and they were not documented in care plans. At this inspection we found people, and their relatives where appropriate, had been consulted about their end of life wishes and they had been documented. This meant staff and professionals would know what the person's wishes were for their future care and final days, and could ensure they were respected. The registered manager told us the service had close links with the hospice, and they worked together to support the person and their family towards the end of life. Staff had received training in end of life care, which meant they had the skills and knowledge to provide effective support at this time. A member of staff told us, "We do constant checks, carry out mouth care, we try to have a member of staff with them at all times if there are no family members visiting". A relative confirmed the effectiveness of this support telling us the staff were, "excellent with end of life care".

Staff asked people for their consent before supporting them. For example staff asked a person for their permission to allow us to look at their bedroom. We also heard staff asking people for their consent before assisting them with a task such as personal care.

Staff were committed to promoting people's independence and supporting them to make choices. One

person preferred to choose and prepare their own food as far as possible. The person's care plan stated, "Care staff to ensure [person's name] is given choices to what food they would like to eat and respect their decisions". The registered manager told us the person was given bread, butter and filling so they could make their own sandwich. They were given milk in a jug so they could put the milk on their cereal.

People were supported to maintain on-going relationships with their families and told us they were able to have visitors at any time. The service was planning to use the new computer based care planning system to improve communication with relatives, through a 'Residents Gateway'. The 'Residents Gateway' was a secure system which allowed relatives to check on the well-being of their family member by accessing their care records and daily notes on-line. They could also communicate directly with their family members named nurse, and send messages and photographs to the person. This was being trialled by relatives at the time of the inspection, and training was being organised for them.

Is the service responsive?

Our findings

At the last inspection in February 2016, we found care plans did not contain sufficient information about people's background and interests to enable staff to provide personalised support. In addition people told us they had not always been involved in developing them. At this inspection in June 2017 we found significant improvements had been made. Many of the people living at Langford Park had complex needs and we found comprehensive care plans had been developed with them. This meant people received care that was responsive to their needs and personalised to their wishes and preferences. Each person had their needs assessed before they moved into the home. From the initial assessments care plans were devised to ensure staff had information about how people wanted their care needs to be met. The PIR stated, "All residents and their families are encouraged to have input into their care plans... Resident preferences are taken into account such as when to get up/go to bed, mealtimes etc. Residents are encouraged to identify who they would like to care for them such as male/female and on occasion's choice of person". Detailed information about people's background and interests was gathered on admission by an activities organiser. On the day of the inspection a new person had moved in and the activities organiser confirmed, "I met the new resident and spent two hours talking to them, getting them unpacked and going through their life story."

Care plans contained clear information about people's mental, physical and emotional health, as well as their support needs, communication needs and daily routines. They provided the information staff needed to provide care in a personalised way. For example, one person was unable to communicate. Their care plan stated, "If [person's name] has music on, staff singing along will cause them to smile. When providing care staff need to make conversation with [person's name], updating them on what is going on in the world". Newly employed staff told us how they supported particular people with communication or emotional difficulties. They told us they had read the care plans, so "knew what to expect".

Care plans were reviewed regularly to ensure they remained current. The new computer based care planning system flagged up when the reviews were due and prompted staff to arrange a review meeting with the person and their families where appropriate. The registered manager told us relatives had also been invited to review the care plans using the 'Residents Gateway', which was currently being trialled. This would facilitate their involvement and contribution to the review process wherever they were, as it was on line.

Information about any changes to people's needs and risks was documented electronically and also shared on a daily basis at the staff handover. One member of staff told us, "The handovers used to be long. Now they are done on a need to know basis, highlighting any changes. We also read the notes on our handheld computer and then click on it to say we've read it, it's a very important part of care". We observed the activity coordinator accessing their handheld computer at the start of their shift to check for any changes in people's care needs before planning the activities for the afternoon. This demonstrated that staff were using the system to understand and minimise immediate risks and provide consistent care.

When we inspected in February 2016 we found that there was one activities organiser with limited time

available to assess and meet the diverse social care needs of everybody at the home. In addition people's spiritual needs were not being considered. At this inspection in June 2017 we found there were now two activities co-ordinators in post who were working with people and their families to identify their interests and preferences with the aim of meeting their individual social needs. There were activities in the communal area of the home which people could join in with if they wished. This included quizzes and games as well as visiting entertainers, animals and birds of prey. There was a church service every month. The activities co-ordinators worked with people individually if required, taking them into town or to the pub. They told us, "We take one person out with their dog. It depends on what people want. We are trying to tailor it as much as we can". They also worked with people on a one to one basis in their room. They told us, "There are people we try and see every day". For example, one person, unable to communicate verbally, enjoyed being read to. A special sensory light system had been installed in their room. A member of staff told us, "The activity worker will do anything for them". People were supported to maintain their hobbies and interests independently if they wished. For example one resident had an area in the garden where they were growing tomatoes and other plants. Another person enjoyed playing guitar and had gone out with the activities co-ordinator to buy some new guitar strings.

The service had a policy and procedure in place for dealing with any concerns or complaints, and people told us they would feel comfortable raising concerns. The PIR stated, "The policy outlines how to handle complaints and timescales for this. Residents, families and friends are encouraged to raise any complaints that they may have knowing that they will be addressed. Complaints can be either formal or informal depending upon the preference of the individuals. Should a complaint be made and it was felt appropriate then changes would be made to the service to ensure improvement". We saw that all complaints had been responded to in line with the complaints policy, and the complainant informed in writing of the outcome. One relative had raised a concern that, on occasion, noise and disruption in the communal area was distressing for their family member. They told us the deputy manager "had listened to them and was taking action". The registered manager confirmed they had responded by asking staff to increase their presence and support in the communal area with the aim of minimising disruption and noise levels.

Is the service well-led?

Our findings

When we last inspected in February 2016 the service had made significant improvements in all aspects of its management, with input from the local authority safeguarding team, the commissioning team and the Quality Assurance and Improvement Team (known as QAIT). At this inspection in June 2017 we checked to see whether the improvements were consistent and had been sustained.

At the last inspection in February 2016 we found the provider had begun to implement a range of quality assurance measures in order to monitor and review the quality of care, including a newly developed audit tool. However, some audits, such as those monitoring accidents and incidents and the environment had yet to be implemented. At this inspection we found there had been significant progress. However, further improvement was required to auditing systems to ensure people's safety with regard to medicines administration, infection control and the use of pressure relieving mattresses.

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

Following the inspection the provider sent us an updated service improvement plan which showed that these issues were being addressed and appropriate action taken.

There was a comprehensive system of audits in place which scrutinised all aspects of service provision and identified areas for improvement. The provider owned two homes, and the registered managers carried out detailed peer audits. In addition the provider carried out unannounced six weekly quality assurance audits. There was also a rolling programme of in-house audits, which looked at all aspects of care and the environment. People living at Langford Park and their relatives were invited to express their views of the service through satisfaction surveys and at residents meetings, with the support of the activities co-ordinator if required. The information from the quality assurance processes was used to develop a service improvement plan, with clarity around responsibility and timescales. Staff had been asked to contribute to this. The provider told us, "If we're going to do quality assurance we need to involve staff. We're looking for good practice and improvement. We need to think about how do we fix it, and when, and whether it's realistic?"

The home was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. Staff and relatives spoke very positively about the management of the home and the support provided. Comments included, "[Manager's name] is on the floor with you. They are really good. It means they're more accessible" and, "In my previous jobs I was always a bit scared of the managers. I can always go and speak to [manager's name]. They are welcoming". A relative praised the consistency of the care provided saying, "The management work hard at that. It starts from the top and works its way down".

The registered manager and provider were committed to the improvement and development of the service. They promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an

open and transparent way in relation to care and treatment.

The provider told us they had recognised that a cultural change was needed and 'this started from the top'. Following the safeguarding process and last CQC inspection they had commissioned an external consultant to mentor them, looking at the whole team and its leadership. They told us they had decided with the mentor that they wanted Langford Park to provide "outstanding care for residents and be a home where people want to work". The consultant had provided leadership and management training and helped them to develop a new values framework based on respect for all, trust, professionalism, genuine relationships and excellent leadership. This had been embedded across the service in its processes and training. The registered manager told us, "I think there has been a dramatic change in the last 12 to 18 months. Our residents are now safe....the safeguarding process was difficult, but it's one of the best things I've ever done. I knew there were big issues and changes were needed...I feel satisfied everything is ok now...I am genuinely proud of Langford Park. I would not have said that 12 months ago". The provider confirmed the positive impact of the changes saying, "Staff are happier and more confident. They are speaking out and more vocal with suggestions at staff meetings and at the staff focus group we developed to help them manage and influence any changes". A health professional told us, "Our team feel privileged to have worked with Langford Park over the last 18 months. We were part of the original safeguarding enquiry and as a result we have been able to experience the improvements made first hand".

A new staffing structure, including the providers, registered manager, deputy manager, and team leaders provided clear lines of monitoring and accountability. The provider said, "There are clearly designated roles and a chain of command. This means [manager's name] is able to focus on their management role... Everyone understands their role. The lines are straightened". This was confirmed by staff who commented, "There is a clear chain of command; it's you, the team leader, the nurse and then management", and, "I think the staff are supported really well. They're strict if they've got to be. If you've got any problems you've only got to ask".

The provider and registered manager worked together to drive the changes and improvements at Langford Park. Weekly management meetings were held where they shared information and any concerns. They were proactive in their own professional development and keeping themselves informed about best practice. The registered manager had attended training sessions including manual handling; train the trainer and supporting people with challenging behaviour. They had delivered training to staff alongside external health professionals. They told us, "I learnt a lot I didn't know before". The provider also attended some of the training with staff and said, "I have made it my business to go on as much training as I can....the provider is part of the team." They were signed up to the 'Social Care Commitment', developed by Skills for Care to improve standards, and part of the Providers Engagement Network (PEN), a forum for providers and managers to learn from each other and provide peer support.

The service had notified the CQC of all significant events which had occurred in line with their legal obligations.

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
Diagnostic and screening procedures	Systems to ensure people received their medicines safely were not always effective.
Treatment of disease, disorder or injury	The management of clinical waste was not safe, which put people at risk due to the potential for the spread of infection. Equipment was not always used in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	Quality Assurance processes were not always effective in assessing, monitoring and improving the quality and safety of the services provided.
Treatment of disease, disorder or injury	