Mrs R E Kelly Mrs B J Kelly and Mrs R E McBride

Langdale Nursing Home

Inspection report

11 The Avenue
Alverstoke
Gosport
Hampshire
PO12 2JS

Tel: 02392581754
Website: www.langdalecarehome.co.uk

Date of inspection visit:
14 March 2016
16 March 2016

Date of publication:
28 April 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 14 and 16 March 2016. Langdale Nursing Home provides accommodation and nursing care for up to 39 older people. During the inspection 38 people were being accommodated. The home cares for a diverse group of people. At the time of inspection 11 of the 38 were people under the age of 60 and the needs of people included those living with dementia, brain injury and multiple sclerosis.

The service had a 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.

The service was last inspected in November 2013 and at this the service was found to be compliant with the regulations looked at.

Staff understood the principle of keeping people safe, but we found serious injuries had not been reported to external bodies or investigated by the registered manager meaning people may not have been safeguarded. Some assessments had been completed as part of the care planning process, but these were not specific to individuals; which meant where a risk had been identified risk assessments had not always been completed. For example almost everyone had a standard risk assessment for falls, but not for specific risks relating to their individual risks. This meant people could have risks, for example aggressive behaviour, but staff were not aware of these risks. Staffing levels met the needs of people, with the home having a static staff group. There was a training programme but not all staff had in date training in all areas, which meant all staff may not have the knowledge to meet people's needs. Recruitment checks had been completed before staff started work to ensure the safety of people. Medicines were administered and stored safely.

Staff had a basic knowledge of the Mental Capacity Act but people's records did not show people's capacity to make specific decisions had been assessed. This meant people did not have their mental capacity assessed and restrictions may have been placed on people without their agreement or being in their best interests. People enjoyed their meals and were offered a choice at meal times. People were supported to access a range of health professionals.

People did not always have their needs planned in a personalised way, which reflected their choices and preferences had been considered. This meant staff may not always have the best information on how to meet an individual's needs and preferences. People felt confident they could make a complaint and it would be responded to. Complaints were logged and there were recordings of investigations into complaints.

People felt the staff were caring, kind and compassionate. The home had an open culture where staff felt if they raised concerns they would be listened to. Staff felt supported by the registered manager and were clear about their roles and the values of the home. Records were not always accurately maintained and this

was not an effective part of the quality audit process. Notifications were not being submitted as required.

We found breaches in six of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Registration Regulation 2009. You can see what action we told the provider to take at the back of the full version of the 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

The service was not always safe.

Safeguarding concerns had not always been reported.

Risks regarding individuals care had not always been identified and risk assessments were not always in place to mitigate the risk.

Recruitment procedures were in place to ensure staff were suitable to work with people at risk.

Staffing levels were planned to ensure the needs of people could be met.

Medicines were safely stored, administered and recorded.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received training or regular supervision, to ensure they had the knowledge and support to meet people's needs.

Staff did not have a good knowledge of the Mental Capacity Act 2005, restraint and of the need for best interests decisions.

People received support to ensure they ate a balanced diet.

People were supported to access a range of healthcare professionals.

Is the service caring?

Good

The service was caring.

People were supported by caring staff who respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personalised care, which was in line with their needs or preferences.

People felt they could complain and complaints were investigated.

Is the service well-led?

Requires Improvement

The service was not always well led.

The manager operated an open door policy and staff were encouraged to share concerns and make suggestions.

People's records were not always accurate and well maintained; the quality assurance process did not identify or address all the issues needed,

Notifications were not always submitted as required.

Langdale Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 14 and 16 March 2016 and was unannounced. One inspector and a specialist advisor in nursing and the care of frail older people, especially those living with dementia, carried out the inspection. We visited the service between the hours of 10:00am and 8:00pm over the two days.

Before the inspection, we reviewed previous inspection reports, action plans from the provider, any other information we had received and notifications. A notification is information about important events which the provider is required to tell us about by law.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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.

During the inspection we spent time talking to ten people, four visitors, six members of care staff, two registered nurses and the registered manager. We looked at the care records of ten people and staffing records of four members of staff. We saw minutes of staff briefings, policies and procedures, compliments and the complaints log and records. Certain policies were sent to us following the inspection. We were given copies of the duty rota for a month, which included the week of the inspection, and a copy of the training plan.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed interactions between people and staff. We received written feedback from two health and one social care professionals.

Requires Improvement

Is the service safe?

Our findings

Staff had knowledge of safeguarding people at risk and had received training to support this, in the last 24 months. When asked, staff were aware of the policies regarding safeguarding and which agencies should be informed if there were safeguarding concerns. People felt safe and were confident staff would raise any concerns if they reported they did not feel safe. However we could not be assured the registered manager and staff were aware of how to recognise abuse or of when to use the policies and procedures to ensure people were protected from abuse. The provider's policy stated that other external bodies should be notified, depending on the seriousness of the concerns. However, it provided no guidance as to how the level of seriousness would be defined. We found reports of separate incidents which related to three people sustaining serious injuries whilst receiving care and support from staff. These serious injuries had not been investigated and no referrals had been made to the local safeguarding team. When asked the registered manager advised us she had not investigated the injuries but had considered making a referral but had decided it was not necessary. The failure to report these incidents means people may not have been safeguarded. Following the inspection we reported these incidents to the local authority responsible for safeguarding matters.

The failure to report these concerns and follow systems and procedures to keep people safe was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to have as much freedom as possible in terms of accessing all areas of the home and the garden. Risk assessments had been completed, but only as part of a process for writing assessment and care planning. For example everyone had a risk assessment for falling, despite some people not having had a fall for over a year. Risk assessments were part of a process rather than looking at individuals and identifying what risk assessments were needed in individual cases. This meant people did not have risk assessments regarding their individual risks. For example care plans included statements like, "Can be aggressive and resistant to care", "Low mood, history of depression", "Skin very thin", but there was no risk assessment attached to these statements or plans developed to reduce the risks. A risk assessment for the person who had 'very thin skin' had not been completed despite the person being injured. Records indicated there had been an incident where a person had their leg trapped whilst getting out of bed. When we looked at the person's risk assessment for the months around this incident, there was no detail about this incident and the risk assessment had not changed. For another person who had sustained an injury during moving and handling the care plan did not give any detail about the incident and had not been updated to ensure staff knew how to prevent this reoccurring. This meant staff did not have the information to know about the risk or of how to minimise the risk.

The lack of effective risk assessments in place to ensure the safety and welfare of people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All people, staff and visitors spoken with told us there was enough staff on duty. As well as nurse and care staff the home employed designated staff to provide activities, kitchen and domestic staff. The registered manager confirmed that a tool to assess the number of staff needed to meet people's needs was not used.

However, they said they would increase staff on duty if this was required. The duty rotas from 21/2/16 - 28/2/16, 28/2/16 - 6/3/16, 6/3/16 – 12/3/16 and 20/3/16 – 26/3/16 recorded consistent staffing levels. This showed there were two registered nursed on duty from 8:00am – 8:00pm with a minimum of 8 care staff working until 2:00pm and a minimum of five care staff working until 8: 00pm. The nights were covered by one registered nurse and a minimum of four care staff. The skills and experience of staff had been considered when the staffing rotas were planned. Staff responded to people in a timely fashion during our inspection and we did not hear call bells ring for long before being answered.

Recruitment records showed relevant checks had been followed to keep people safe. Checks with the Disclosure and Barring Service were made before staff started work. Application forms had been completed and where available staff's qualifications and employment history including their last employer had been recorded. The Pin (Personal Identification Number) of nurses was recorded, demonstrating the provider had ensured they had the skills and qualifications to carry out their role.

One person told us the nurses and sometimes the managers "delivered the medicines on the dot". The provider's medicines were kept in two locked trolleys secured to the wall. There was a good stock control and a good system of disposal of unwanted medicines. Medicines were stored appropriately. The medicines rooms had a refrigerator and the temperatures of this and the room were recorded daily and were continually within appropriate limits. Topical medicines in people's rooms all had 'an opened date' recorded which was good practice. Staff administered medicines in a professional and unhurried manner. Nurses had received medicines training during the previous year and they had regular medicines competency assessments with the manager or the home's deputy manager. Nurses had a good knowledge of specific medicines and potential complications.

Requires Improvement

Is the service effective?

Our findings

People told us they were happy with the staff and felt they had the skills to care for them. Some people told us the staff had a good knowledge of their medical condition, which helped the staff care for them.

Records held showed staff had a good induction. Each new member of staff had their own file and worked through each unit, which resulted in a test paper, which was sent away to be marked and if the mark indicated it was needed, the staff member would have a mentoring session. The Registered manager informed us this could go towards 'The Care Certificate' which is the standard employees working in adult social care should meet before they can safely work unsupervised. It gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Staff member's records showed staff were having supervision, but along with annual appraisals these were not happening regularly for all staff. Staff told us they felt supported in their role and could contact the management team at any time. The information given during the day and in the PIR showed all staff did not receive training in all areas. For example only 32% of staff had completed training on malnutrition care and assistance with eating, 53% of staff had completed training on moving and handling. 19% of staff had completed training on dementia care and 8% on positive behaviour support. The lack of staff trained in moving and handling could have contributed to the accident to one person when they were being moved. Oxygen was used in the home which should not be used by staff who have not received appropriate training. There was no record staff had received training in this area. This meant staff may not have had the skills to care for the diverse needs of people living at the service.

The lack of staff training to ensure they could meet people's needs and the lack of regular supervision and annual appraisal was a breach of Regulation 18 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Only 6% of staff had received training on Mental Capacity Act and Deprivation Of Liberty safeguards. Staff had a basic knowledge about mental capacity and how it affected people who lived at the home. 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 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. The registered manager informed us restraint was not used in the home. However when we looked at people's records, we saw bed rails were used. These had not been considered a restraint. Within the brief care plan for bed rails was a statement which recorded they were used for safety rather than restraint. There was no evidence people had been asked for their consent to use bed rails and no mental capacity assessments had taken place with people. This reflected people had restraints without it being considered and there had been no assessment to test people's capacity. In one lounge we saw a person's movement was restricted by a (Hydro tilt) chair, (a chair which provides pressure and posture management and can be tilted backwards) they were sat in. We were advised this was for their safety to prevent them falling when moving but there had been no assessment of the person's capacity to see if they could agree or disagree to this restriction. No consideration to a best interests meeting, involving others in this decision had been

made.

The lack of assessing people's capacity and having regard of the Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had an understanding of the Deprivation of Liberty Safeguards (DoLS) and some staff had received training to support their understanding. One application to deprive people of their liberty had recently been made to the local authority responsible for making these decisions.

People were supported to have a sufficient amount to eat and drink and received a balanced diet. People could eat their meals where they wanted, which included in the lounges, dining areas and in their own rooms. The cook had lists of people's nutritional needs, which recorded if people were on any special diet, including vegetarian, diabetic, low potassium and pureed. People who were on pureed diets were served these in a way which ensured they still looked attractive. People who needed support with eating their meals were given this in a respectful and patient way. Where necessary people had been referred to the SALT (speech and language therapist) to ensure the risks associated with eating and drinking had been assessed. People's nutritional assessments included screening using the MUST (Malnutrition Universal Screening Tool) which is a five step screening tool, to identify adults who are at risk of malnutrition.

Where it was deemed appropriate people were referred to health professionals as necessary. People told us they had access to health professionals and the staff would support them to access these appointments. Details of the referrals and appointments were maintained in people's records. A GP practice told us, "the home manages complex patients well. Any advice and guidance has been followed and the staff were cooperative and communicated well. The GPs are contacted for relevant issues and queries and asked to visit appropriately."

Good

Is the service caring?

Our findings

Everyone we spoke with only had positive things to say about the care they received, the staff and the home. One relative told us, "I cannot fault the care and the staff are lovely". Two visitors who visited every day at different times told us, "We are always made welcome, and kept in touch with any changes". One person told us "The staff are really great, I just ask for something and there it is".

The home had a static staff group and did not use agency staff. It was clear the staff knew people well and treated people with kindness and compassion. The staff were cheerful and the atmosphere at the home was relaxed and people seemed contented and happy. When offered biscuits we witnessed a person ask for 'special biscuits'. The staff member had to go to the kitchen to get the person's preferred biscuits but they did this with good humour and cheerfully. The person told us "You see all I have to do is ask and all the staff are the same, they all want to help and do it with a smile". Staff were aware of the person's needs and choices.

People felt included and able to make decisions regarding their own care. This was harder to evidence for people who were not able to communicate with us as records did not reflect people had been involved with them. We were told one person had an advocate as they had no family or friends who could support them.

Staff spoke with people while they were providing support in ways which were respectful and friendly. When we checked records we could see staff addressed people by their chosen names. Staff ensured resident's privacy was protected by providing all aspects of personal care in their own rooms. We noted that staff knocked on people's doors and introduced themselves before entering people's rooms.

People were encouraged to make choices during the day, including the clothes and jewellery they chose to wear, activities they took part in and in respect of food. People's cultural and spiritual needs were taken into consideration and accommodated. For example one person told us that their minister visited the home regularly so they could receive communion.

Requires Improvement

Is the service responsive?

Our findings

People had assessments before they moved into the home and where possible people were encouraged to come and give the home a try before they moved in to ensure the home was suitable for them. From the assessments people had care plans developed. It was not possible from the way care plans had been written to establish people had been involved in the development of their care plans. Care plans had the same format and tended to include information in the same areas, rather than being individual to each person's needs and preferences. However feedback from people and professionals was of a positive nature. One health care professional told us, 'I have placed people all of whom have been very particular about how their care needs are met. I have found the staff to be very good at understanding what each person's needs were. I have had consistent positive feedback from the service user and their family'.

We found people's records, did not include important information and whilst being reviewed on a regular basis the reviews did not include relevant updated information. When looking at another person's care plan, it recorded information such as 'Deteriorating, very poor diet intake. Records of this person's fluid intake were viewed and they recorded a very low fluid intake. Despite this there was little information to guide staff on how they should support the person, with their food and fluid intake. One person had sustained significant injuries. A staff member told us this person had a history of bruising and a behaviour which could cause themselves injury, however their care plan did not reflect this or the support staff could provide. When we spoke with the registered manager we were given a different account and were advised the person had had bruising to their face and body for many years. The person had relevant blood tests but nothing had been detected. It was unclear at this time how the person had sustained their injury to their chest. The care plan gave no detail of the history and no photographs or body charts had been maintained to record the bruising and injury. This meant care plans did not have adequate information to ensure people received responsive personalised care.

The provider did not use "as and when necessary" (prn) care plans or protocols which are considered to be an essential aspect of safe medicines management (NICE, 2014). Pain assessments for people were not used. Staff told us "We know residents so well that we know when they need pain killers". As a consequence the signs a person could have been in pain were not specifically recorded and the lack of guidance left this open to staff personal interpretation which may vary between staff members.

People's chosen preferences regarding their care were not always up to date to ensure people received their care according to their wishes. For example, when looking at one person's care plan regarding their preferences it recorded they liked to go to bed at 10:00pm and spend time in their room. However daily records showed for the last seven days the person had spent the majority of time in the communal lounge. Over the last twelve days the person had been in bed before7:00pm on eight of these days. There was no record of why the change had happened and the person was unable to tell us. We could not be assured the person's was being cared for in accordance with their wishes. In another care plan we noted the persons wishes regarding resuscitation had been changed in December 2015 in the summary, however in the more detailed care plan this change had not been documented, which meant there the person may not have had their preferences respected.

The care and treatment of people was not always person centred. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an activities programme which recorded a range of social activities which were on a group or individual basis, with designated staff to provide activities. The home had designated staff to provide activities and also a range of outside entertainers who came into the home. People were given the choice of joining in activities and those who took part told us they enjoyed the range of activities. One person told us, "There are mainly older people living here but also quite a few young ones like me and some others, so we have things in common and when we do activities it's not just the same old sing-songs the older people might want where we want to do other things. That's the good thing it means we get to do what we choose and not what is just on the list".

The registered manager kept a log of all complaints and compliments which had been made. People and visitors told us they could tell staff if they had any concerns and they were confident staff would act on the information. When complaints were made these were investigated and a record was maintained and the outcome of the complaint was recorded.

Requires Improvement

Is the service well-led?

Our findings

All feedback from people, staff, visitors and health and social care professionals was of a positive nature. A member of staff told us, "This is a wonderful place to work, with a fantastic team and an incredibly supportive manager".

A registered manager was in place at the time of our inspection. People and staff described the registered manager positively. However the registered manager demonstrated a lack of understanding about what action they needed to take to ensure the service was meeting people's needs and ensuring their safety and welfare. A record was made of accidents, but incidents were not recorded, and the records maintained were basic and did not relate to the daily records or people's care plans. There had been no analysis of the recorded accidents, so no learning was possible. The registered manager was unable to explain why injuries had occurred and could not demonstrate they had investigated these. This had resulted in CQC, safeguarding and RIDDOR (reporting of Injuries, disease and dangerous occurrence regulations) not being notified of some serious injuries. We found records where three people had sustained serious injuries, which we had not been notified of.

The failure to notify CQC of theses injuries was a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

Whilst it was clear people and staff were involved in the development of the service there was very little evidence of this in terms of meetings and records. Questionnaires and surveys had not been completed to try and gain feedback on the service offered. We were shown a range of reviews which had been completed with people after their first week of living at the home. However we could not see this information had been collated for any common themes or if there had been action taken on the responses. Meetings with people living in the home had not taken place, but people told us they could makes comments to the management team and staff. Some staff meetings took place and a monthly team brief was produced which staff had to sign to say they had read. The last team brief included the code of conduct for health and support workers. Staff were aware of the whistle-blowing policy. During the inspection we found the registered manager responsive to our feedback and wanting to improve the quality of service to people. For example one person told us they could not access the homes Wi-Fi. When we mentioned this to the registered manager they told us they would ensure the person was assisted with this. When we discussed our concerns with the care plan and associated records of one person at the end of the first day the registered manager had worked and improved these when we came back for the second day of the inspection.

A range of audits were carried out monthly. A medicines audit was carried out monthly. The audits identified some issues, for example a small number of signatures being missed. However, the audit had not identified the out of date medicines policy or the use of hand written medical administration records. Care plan audits were carried out regularly and these had identified some areas which needed to be improved for individuals. For example, the lack of recording had been identified for the blood glucose level or the record of applying topical medicines to people. The registered manager had not identified the concerns we had identified

about care plans and risk assessments not being updated as people's needs changed and the records not being personalised. However when we discussed these areas with the registered manager they could identify the gaps too.

Records were not accurately maintained and needed to improve. Whilst some areas had been picked up by the provider we identified other areas. For example the recording of incidents and accidents needs to be improved in the home. Records regarding injuries or pressure sores needed to be improved. No photographs or measurements were routinely maintained, which made it difficult to evidence the seriousness of the wound/ injury and if they were healing. In some people's nutritional care plans they identified staff were to observe food and fluid intake. This did not always result in people having food and fluid records. When fluid records were maintained, these did not always record a target intake and they were not always totalled. This meant staff would not know the total fluid intake they should support the person to have. Some care plans identified people needed to be moved on a regular basis, however not all these people had records to evidence this was taking place.

This failure to ensure accurate records and effective systems to monitor the service to drive improvement was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had not ensured they notified CQC of significant events that occurred in the home. Regulation 18(1)(2)(a)(iii)(b)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always person centred. Regulation 9 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a lack of assessing people's mental capacity and regard to restraint in regards of the Mental Capacity Act. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of effective risk assessments in place to ensure the safety and welfare of people. Regulation 12 (1) (2) (a) (b) (e)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected because the systems to ensure safeguarding concerns were investigated and reported were not effectively operated. Regulation 13(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate an effective system to monitor the service to drive improvement and maintain accurate records. Regulation 17 (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The lack of staff training did not ensure staff could meet people's needs and staff were not receiving regular supervision or an annual appraisal. Regulation 18 (2) (a)