

Langford Park Ltd

Langford Park

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Requires Improvement ●

Summary of findings

Overall summary

About the service

Langford Park is a 'care home' registered to provide accommodation, nursing and personal care support for up to 35 older people, people living with a dementia and younger people with a physical disability. At the time of this inspection there were 32 people living there.

People's experience of using this service and what we found:

On coming into post in June 2020 the registered manager had identified failings in the management of the service and quality assurance processes. Action was being taken to address these failings. However, the issues we found related to recording and documentation showed they were not yet fully effective or embedded. In addition, the service had not met its regulatory requirements to notify us of certain events as required by legislation since the new manager came into post.

There was an open, transparent and positive culture at the service. Staff told us they felt valued and part of a dedicated team. They were excited about the progress being made and future direction of Langford Park.

The new manager and provider had reviewed the quality assurance programme and made changes to make it more effective. A service improvement plan was in place. Changes already in progress included the strengthening of the leadership team and a review of staff roles and responsibilities; improved communication; staff induction, supervision and training; investment in the environment and the replacement of equipment which was no longer fit for purpose.

Improvements to the quality and consistency of care plans had continued since the last inspection. Care plans were reviewed regularly, and when people's needs changed. Since coming into post the registered manager aimed to include family members and the resident when possible in the planning of their care, which hadn't always been the case previously.

People told us, and records showed, staff numbers had fallen below safe levels at times, however we were reassured that this was no longer the case, following a successful recruitment programme. Robust recruitment systems were in place.

The nursing team had been expanded and was now better supported with clinical oversight from the registered manager. There were safe systems in place for the administration of medicines, which meant people received their medicines as prescribed.

There had been a focus on staff training, including the development of a team leader training programme and specialist training to equip staff to meet people's complex needs.

People were safe living at Langford Park. Staff were working closely with external health and social care professionals to identify and manage risks to people. The provider had good systems to manage

safeguarding concerns, accidents, infection control and environmental safety. The service was clean and there were effective processes to prevent the spread of infection.

The service had continued to develop and provide a programme of activities for people, working within the restrictions of the Covid-19 precautions in place. People were supported to maintain contact with friends and family.

People and their relatives told us they knew how to make a complaint and were confident they would be listened to and action taken.

The service was committed to ensuring people received the support they needed at the end of their lives to have a comfortable and dignified death

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

Rating at last inspection (and update)

The last rating for this service was requires improvement (published 1 November 2019). There were no breaches of regulation. The service has now improved to good.

Why we inspected

We undertook this focused inspection to check the quality and safety of the service, as there had been two previous ratings of requires improvement and one of inadequate. This report only covers our findings in relation to the Key Questions Safe, Responsive and Well-led which were rated requires improvement at the previous inspection.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to good. This is based on the findings at this inspection.

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 coronavirus and other infection outbreaks effectively.

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

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?

Good ●

The service was safe.

Is the service responsive?

Good ●

The service was responsive.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

Langford Park

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 a specialist advisor with expertise in nursing care.

Service and service type

Langford Park 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. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave a short period notice of the inspection. This was to make necessary arrangements to minimise risks related to Covid 19 for our site visit.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with four people who used the service and one relative about their experience of the care provided. We spoke with nine members of staff including the provider, registered manager, deputy manager, nurses and care support workers. 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 reviewed a range of records. This included seven people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance and training records. We received feedback from three relatives and two professionals who regularly visit the service.

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 requires improvement. At this inspection this key question has now improved to good. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management

- People were safe, and this was confirmed in feedback from people, relatives and external health professionals
- At our inspection in September 2019 we found documentation relating to the management of risks, did not consistently support staff to recognise risks and keep people safe. At this inspection we found the provider had continued to improve the way they managed risk, however further improvements were needed to ensure the consistency and accuracy of documentation and recording.
- Information about changes in people's needs was evident in the body of the care plan and staff were aware, but this had not always been added to the summary of information on the front sheet. For example, related to changes in the dietary needs of a person at risk of choking, or a person very recently bereaved. We raised this with the registered manager, who rectified this immediately.
- We found significant gaps in the repositioning records for two people in the week before the inspection. There was no evidence of pressure damage however. The registered manager confirmed staff were supporting people to turn in line with their care plan, but not always recording it. They took immediate action, reinforcing to staff the importance of documenting all the care that is completed, and ensuring this was closely monitored.
- There were detailed risk assessments in place with clear guidance for staff about how to minimise the risks. This included risks related to nutrition, falls, skin breakdown, moving and positioning and behaviour that challenges. The risk assessments were reviewed and updated monthly. The electronic care planning system meant this information was easily accessible for staff.
- Staff had a clear understanding of people's needs and risks, and how to keep them safe. A relative told us, "They have a good understanding of the complexity of my [family members] condition, when to reassure them, make sure they don't fall and that they are clean, tidy and to make sure they have enough water, tea, food etc. otherwise they simply wouldn't eat."
- Records showed that concerns about increased risks had been escalated promptly to external health and social care professionals, and guidance followed. This was confirmed in feedback from a visiting health professional, who told us "I feel that the staff know and understand their residents and appear responsive and positive to care-planning and evaluating interventions in meeting their needs."
- Health and safety checks in the home had been carried out. There was a programme of regular maintenance to the building and servicing of equipment. All lifting equipment, beds, commode and shower chairs were in the process of being replaced. A new call bell system had been installed since the last inspection which enabled the call bell response times to be monitored.
- Systems were in place to protect people in the event of an emergency. Contingency plans gave information to staff on action to take for events that could disrupt the service, and personal emergency evacuation plans were in place. The registered manager was planning to reinforce understanding of fire

safety roles and responsibilities at the next staff meeting.

Preventing and controlling infection

- There were robust systems in place to assess and respond to risks regarding infection prevention and control, including those associated with Covid-19. A relative told us, "We think that the home has done a great job in preventing Covid-19 getting into the home, whilst balancing the needs of the residents. Obviously, it was difficult during lockdown when we couldn't visit at all, but measures are now in place with restricted visiting, which whilst is difficult, we know to be a necessity."
- We were assured that the provider was minimising the risk of visitors catching or spreading infections; following shielding and social distancing guidelines; admitting people safely to the service; promoting safety through staff training and the layout and hygiene practices of the premises; and accessing testing for people using the service and staff. The majority of staff were using Personal Protective Equipment (PPE) effectively and safely. We saw one member of staff pull their mask down when communicating with a person with sensory loss and discussed this with the registered manager. They undertook to address this and remind staff of the guidelines and the potential risks.
- There were specific measures and training in place where a person required aerosol generating procedures.
- The service was vigilant in monitoring the wellbeing of people and staff. People had their temperature checked twice daily, and staff had their temperature checked and recorded before starting their shift. A member of staff told us, "We need to know the residents very well to know something is wrong with them. Some of them can't tell us, so we know to look for soft signs. We are testing everyone and get swab results back quickly."

Using medicines safely

- There were suitable systems in place for the storage, ordering, administering, monitoring and disposal of medicines. A computerised medicines administration system was in place, to ensure efficiency and safety.
- People received their medicines safely, in the way prescribed for them. One person told us, "My tablets are spot on. I don't get headaches or seizures. I have no complaints about anything. They help me a lot."
- People's care plans included detailed information about their prescribed medicines and how they needed and preferred them to be administered. There was clear guidance regarding the administration of PRN (as required) medicines, and medicines required at prescribed times, for example to manage the symptoms of Parkinson's disease.
- Staff received medicines training. Their competency was checked to make sure they gave medicines safely, with annual reassessments being planned.
- Regular medicines audits were completed. These identified any necessary actions which were put in place to improve the way medicines were managed.

Staffing and recruitment

- Some concerns were raised by relatives about staff availability in the period before the inspection. The providers quality assurance documentation confirmed that staffing had been below safe levels at times. We were reassured however that people's needs had continued to be met. New staff had now been recruited, including additional nurses. A member of staff commented; The number of staff is better and the quality of the management. The nursing team have more clinical support. Residents have better care. Staff have much more time to spend and give quality care, not just the basics. "
- Staff were recruited safely, and appropriate checks were carried out to protect people from the employment of unsuitable staff. The registered manager endeavoured to ensure staff checks were reviewed annually in line with company policy.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe at the service, and this view was shared by relatives.
- People were protected from potential abuse and avoidable harm by staff who had regular safeguarding training and knew about the different types of abuse. Their knowledge was reinforced through discussion in team meetings and supervision.
- Staff told us they felt confident to report any concerns and knew that action would be taken.
- The provider had effective safeguarding systems in place. Records showed that concerns had been escalated appropriately and promptly.

Learning lessons when things go wrong

- There were systems in place to capture relevant information from incidents and ensure action was taken to minimise recurrence. The computerised care planning system enabled the registered manager to have oversight in real time of any accidents or incidents that occurred. This information was reviewed weekly to identify any trends or wider actions necessary to minimise future risks.
- The registered manager was proactive in promoting staff reflection and learning. They told us, "I have shared the [inspection] feedback with all the staff so they can share in improving the service."

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. There were no breaches of regulation. At this inspection this key question has now improved to good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Improvements to the quality and consistency of care plans had continued since the last inspection.
- People living at Langford Park had a wide range of support needs. The computerised care plans were person centred, containing detailed information about people's physical and emotional support needs, preferences, background and interests. A visiting health professional told us, "They have got some really complex patients there and I think they respond well to that complexity - in particular the younger patients have some freedom and are supported to go out, independently if possible."
- Each person had an individual Covid 19 care plan to promote their safety and the safety of others if they should become infected. For example, one person living with dementia was identified as having minimal understanding of isolation implications should they contract the virus.
- Relatives had access, with the persons consent, to care plans on the computerised care planning system, and people were made aware they could access their records on the homes computers if they wished.
- Care plans were reviewed every six months, or if people's needs changed. However, some people and relatives told us they had not been formally involved in the care plan development or review. We raised this with the registered manager who told us, "The aim is always to include family members and the resident when possible in the planning of their care. This is certainly the case with all the new residents since I started in July. When residents arrive and the family visits for the first time, we take this opportunity to discuss likes/dislikes, wishes etc which is then added to the clinical care plan that has been devised from the pre-admission assessment." This was confirmed by a person who had recently moved to Langford Park.
- Staff told us the care plans provided the information they needed to support people safely and in line with their preferences. They were positive about the effectiveness of handovers and other methods of keeping them informed about changes to people's needs.
- There was a key worker system in place. This meant a named member of staff acted as key point of contact for the person and others important to them, providing continuity and further promoting the provision of personalised care.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- The service had continued to develop and provide a programme of activities for people, working within the restrictions of the lockdown. This included indoor activities, a bird of prey exhibition, and interactive musical events in the garden, with people participating through the lounge windows. Daily one to one activities were provided for people in their rooms.
- The activities coordinators had worked to meet the social needs of more active people, who could not go

out in the way they had previously. This included identifying shared interests, which people could enjoy together, playing computer games and visiting each other in their rooms. We spoke with one person who enjoyed the outside space, looking after the chickens and growing tomatoes.

- People were supported to maintain contact with friends and family during the lockdown. A covered area was constructed in the garden for socially distanced visits, and the garden area had been secured to make it safer for people to use. Information technology enabled people to 'meet' via the computer.
- The activities co-ordinators had a good understanding of people's likes and dislikes and used this to plan activities. This information was kept in a file in each person's room and kept up to date by key workers and other staff.
- People were supported emotionally, for example attending the funeral of another resident and planting a commemorative tree in the garden. Special occasions such as birthdays were celebrated with a meal of the person's choice and a birthday cake, for example with a horse on it, for a horse racing fan.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Care records contained detailed information explaining how people communicated and the support they needed. For example, "X is unable to read or write but they are able to identify objects in pictures. Speak to X in simple words slowly and clearly. If they do not understand, staff should try showing them pictures and get them to point out what they need." We observed staff following the guidance in care plans, giving people time to respond and checking their understanding.
- Documents could be provided in a variety of formats if required. Text could be enlarged for people who wanted to read their care plan on the computer.

Improving care quality in response to complaints or concerns

- There was a complaints policy and process in place, and a box in the reception area where people could raise complaints anonymously if they wished. Complaints were documented with a summary of the concern and the response. This was reviewed by the management team to ensure appropriate action had been taken and any trends or patterns identified.
- People and their relatives told us they knew how to make a complaint and were confident they would be listened to and action taken.

End of life care and support

- The service was committed to ensuring people received the support they needed at the end of their lives to have a comfortable and dignified death. Care plans contained information about people's wishes for the end of their lives, which meant their wishes would be known and respected by staff.
- Safe ways had been found for relatives to visit their family member at end of life, in line with national guidance. Feedback from one relative stated, "May I take this opportunity to say how grateful we were for the professionalism, dedication, care, support and sympathy your staff at Langford gave my [family member] in their final couple of months."

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 requires improvement. There were no breaches of regulation. At this inspection this key question has remained the same. 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. 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

- At the last inspection in September 2019 we found systems to monitor the quality of the service were not fully established or embedded. This was still the case.
- On coming into post in June 2020 the registered manager had identified failings in the management of the service and quality assurance processes. Action was being taken to address these failings, however the issues we found related to recording and documentation showed they were not yet fully effective or embedded.
- Although safeguarding concerns had been escalated appropriately to the local authority, the service had not met its regulatory requirements to provide us with statutory notifications as required. For example, we had not been notified when a person developed a Grade 3 pressure ulcer, or when another person experienced psychological harm due to a deterioration in their mental health.
- The manager had been employed as director of care and had also registered as the manager of Langford Park to improve the quality and safety of the service. They were highly visible, wearing a bright red tunic, allowing them to be easily identified by people, staff and visitors. They had spent four weeks working alongside staff to deliver care. They told us, "Staff needed leadership on the floor. Them seeing me do it made them proud to do it. It's much better than it was. They take pride in their work."
- The quality assurance programme had been reviewed and changes made to make it more effective. It was comprehensive and overseen by the provider with the support of the registered manager, who provided clinical expertise. The views of people, relatives, staff and visiting professionals were gathered via surveys and informal feedback.
- A service improvement plan was in place, to address the issues identified by the quality assurance programme. Changes were ongoing and included the strengthening of the leadership team and a review of staff roles and responsibilities; improved communication; staff induction, supervision and training; investment in the environment and the replacement of equipment which was no longer fit for purpose.
- The provider had created a risk management group, to review, rate and manage any wider risks identified across their services, for example related to Covid 19.

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

- There was an open and transparent culture at the service. During the inspection the provider, registered manager and staff team were open about the previous failings at the service, the work they were doing to address them and where improvements were still required. They welcomed the feedback given, immediately addressing any concerns raised.
- People and staff told us the management team were approachable and supportive. One member of staff commented, "Things have changed a lot since the registered manager has come in. You say something to them and its dealt with straight away. Such a good team. the whole atmosphere. There's nothing I don't like, I'm really comfortable, part of the team. I fit in. "

Engaging and involving people using the service, the public and staff, fully considering their equality

- The provider was proactive in keeping people, relatives, staff and other interested parties up to date with developments at the service in relation to Covid 19. They posted weekly videos on social media outlining the strategies in place to protect people, including information about the numbers of staff currently shielding and testing arrangements.
- Satisfaction surveys were sent to people and their relatives every six months to request their views. People were supported by staff to complete them if required. Face to face meetings for people and their relatives were not possible due to Covid guidelines, so the idea of virtual meetings on line was being explored.
- Staff had a voice in the running of the service. They were asked for their views in a staff survey and at staff meetings. There were also plans to restart the staff focus group.
- Staff told us they felt valued and supported. A staff wellbeing survey was completed to determine how well they were coping during the pandemic. There was a dedicated staff area with snacks, drinks and chocolate bars and they were given 'wellbeing' packs containing vitamins, herbal teas and massage oil. An awards ceremony was planned with a 'heroes' badge for staff who worked during the lockdown.

Continuous learning and improving care. Working in partnership with others

- The registered manager was working to develop the confidence, skills and effectiveness of the staff team. They had run a training session on supervision for team leaders and developed a six-month team leader training programme to promote leadership skills and clinical knowledge.
- There had been a recognition that staff needed more specialist training to meet the more complex needs of some people at the service. A member of staff told us, "A lot of things are being looked into and sorted out. We've got new everything. It's exciting. I feel well supported, and really supported with the training as well. Its helping with my confidence."
- The registered manager and staff team were working in partnership with external health professionals, for the benefit of people living at Langford Park. Feedback stated, "The weekly GP ward round is now more organised and attended by either the registered manager or one of the trained nurses. They seem to have a really good knowledge of the patients. They have engaged with a new initiative of a two weekly MDT (multi-disciplinary team) ward round and seem to be following the care plan amendments suggested by the OT and physios from the community team in a way that didn't happen previously."