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 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 dementia; a learning disability and younger people with a physical disability. At the time of this inspection there were 23 people living there.

People's experience of using this service and what we found
Since the last inspection the provider had been working to improve the quality and safety of the service. They had commissioned an external consultant and continued to work with the local authority quality assurance and improvement team. Failings in the service had been identified and the provider had been working to address them. However, progress had been hampered by two unsuccessful managerial appointments in two years and the impact of the Covid 19 pandemic. A new momentum had been created by the new manager, who was in the process of introducing new systems and processes, and a clearer structure with more effective monitoring and accountability. However, these changes had yet to be fully established and embedded. The manager told us, "I feel the home is safe and well led now. It wasn't three weeks ago, but we are getting the systems and processes in place."

Improvements had been made to the management of risk; but further improvements were needed. There were gaps in recording related to the repositioning of people at risk of skin breakdown, nutrition and hydration and the safety of bed rails. Not all staff had not completed their mandatory training, which meant their knowledge and skills were not up to date. The manager was aware of these issues and was addressing them. They had also identified that risks related to the environment had not been managed since the last inspection, including the maintenance of equipment and emergency plans. Measures were now in place to minimise these risks, with systems to monitor them regularly.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, further consideration was needed related to the use of images on social media for people without capacity to consent.

People told us they felt safe living at the service. One person said, "I love Langford Park. I like the company. Its more than safe." Staff knew people well and had a good understanding of their needs and risks. People told us they were kind and caring. They felt respected and included in decisions. Risks associated with people's care had been assessed and guidance was in place for staff to follow. Care plans were detailed, person centred and reviewed regularly. People had been referred appropriately for support from external health care professionals. There were improved systems in place to ensure information about any changes in people's needs was shared promptly across the staff team. A member of staff told us, "There is good information sharing. It feels more structured. You know what you are dealing with."

People received their medicines safely, and in the way prescribed for them. The provider had systems to

manage safeguarding concerns, accidents and infection control.

Overall relatives were extremely positive about their communication with the home in relation to their family member. They told us they had contributed to their care plan and been kept informed about their well-being. They valued being able to access the 'relatives gateway' on the computerised care planning system, and view the support being given to their family member in real time.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of Safe and Well Led the service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
•Model of care and setting maximises people's choice, control and independence

Right care:
•Care is person-centred and promotes people's dignity, privacy and human rights

Right culture:
•Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives

The service's vision and values centred around the people they supported. The organisation's statement of purpose documented a philosophy of maximising people's life choices, encouraging independence and people having a sense of worth and value. Our inspection found that people were encouraged to lead rich and meaningful lives in line with their individual preferences and interests. This location may not be ideal for some people who would want to access the local community independently. However, people's independence and participation within the local community was encouraged and supported. The manager recognised that accessible communication and staff knowledge of people with a learning disability could be improved, and made a commitment to do so.

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 07 September 2021) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected
This inspection was prompted in part due to concerns received about the management of risk; staffing levels; support with personal care and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We found no evidence during this inspection that people were at risk of harm from these concerns.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has not changed from requires improvement based on the findings of 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 COVID-19 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, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

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 Health and Social Care Act 2008.

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 an inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type.
Langford Park is a 'care home' with nursing care. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection the service had a manager who was not yet registered with the Care Quality Commission.

Notice of inspection.
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service and five relatives about the care provided. We spoke with 11 members of staff including the provider, manager, chef, nursing and care staff. We also spoke with the external consultant commissioned by the provider. 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.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at a variety of records relating to the management of the service including quality assurance records; meeting minutes and training records. We received feedback from a professional who regularly visited the service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management.
At our last inspection we found the systems to monitor and manage risks were not always effective. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found there had been improvements and the provider was no longer in breach of this regulation, however further improvements were needed.

● Risks to people had been assessed, including risks related to nutrition, falls, skin breakdown, moving and positioning. Care plans contained guidance for staff about the most effective way of minimising these risks and supporting people safely. However, improvements were needed in recording related to repositioning charts, bed rail checks and food and fluids. This meant it was not always possible to see if people had received the support they needed to minimise the risks. The manager had identified this and been proactive in addressing it. This had led to improvements but remained a 'work in progress.'

●People were potentially at risk, because staff knowledge and skills were not consistently up to date. Meeting minutes showed the manager was aware and had raised it with staff, with a deadline for completion of all mandatory training.

●Risks related to the environment had not been managed since the last inspection. This included the maintenance of equipment and emergency plans. This had been identified by the providers quality assurance processes in September 2021, but only been addressed since the new manager had been in post. Measures were now in place to minimise these risks and were regularly reviewed.

●People and their relatives told us it was a safe service. People told us, "I love Langford Park, I like the company. It's more than safe." "They look after me so well. No faults. I had a lovely bath and hair wash. Staff have a good understanding of the help I need."

●Staff we spoke to, including agency staff, had detailed knowledge of people's needs and risks and what action was needed to keep people safe. A member of staff described how they were able to work with people who refused support, by giving them space and encouragement. Relatives commented, "When mum has episodes, they know what to do and are straight on it" and, "The staff are very careful when they hoist him, he doesn't like it, but he feels safe when they do it."

●People received the support they needed to manage risks related to nutrition and hydration. A member of staff told us, "We are trying to improve fluids daily, and are getting on top of everything." One person said, "This is my third cup of tea this morning, they look after me very well!"

●A new 'dining experience' was planned to further promote nutrition and hydration. A red tray system would enable staff to easily identify people who needed assistance with eating or were at risk of choking.

●Records showed, and relatives confirmed, that people had been referred appropriately for support from external health professionals. For example, the service worked closely with the speech and language team

(SALT) to minimise the risk of choking. However, improvements were needed to ensure the information needed for an assessment was available when the SALT team visited.
● There was improved communication across the service to review risks to people and the actions required to minimise them. This included daily "stand up meetings" and a detailed handover sheet. The information was shared electronically across the staff team, so all staff, as well as agency staff, were kept up to date. Staff told us these processes were effective at keeping them informed.

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 MCA 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.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found overall the service was working within the principles of the MCA, although further consideration was needed related to the use of images on social media for people without capacity to consent. Appropriate legal authorisations were in place to deprive a person of their liberty, and this was being closely monitored.

Using medicines safely
At our last inspection the provider had failed to ensure the safe administration and storage of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found there had been improvements and the provider was no longer in breach of this regulation.

●Effective systems were now in place to ensure people received their medicines safely and in the way prescribed for them.
●There was a 'medicines champion' in post with responsibility for medicines management, with oversight by the manager.
●Medicines were administered by the nursing team, who had the training and competence to do so safely. Knowledge and skills were checked to ensure they remained up to date.
●There were suitable systems in place for the storage, ordering, administering, monitoring and disposal of medicines. Staff told us the computerised medicines administration system was efficient and safe.
●Medicines requiring additional security were managed in line with national guidelines.
●Guidance was in place for staff to make sure any medicines prescribed to be given 'when required' were administered to people when appropriate.
●The service had reviewed the administration of medicines given covertly, to ensure this was in the persons best interest, in line with the Mental Capacity Act 2005.
●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
●Since the last inspection quality assurance systems had identified that the systems and checks in place to recruit staff safely were not fully effective. The manager had now taken ownership of recruitment processes, to ensure they were thorough, and people were protected from the employment of unsuitable staff. This

meant pre-employment checks were done, which included references from previous employers and Disclosure and Barring Service (DBS) checks completed. In addition the manager planned to ask people living at the service to be on the interview panel, and contribute to the vetting process.
● People and relatives told us that there weren't many staff around on occasion, and staff were busy, but this did not impact on their support. Comments included, "I have never felt that she has gone without the help she needs", "The staff check on her constantly when she is in her room. She told us of this" and, "If Dad rings his buzzer in the night, they will attend and record it in his notes."
● The provider used a dependency tool to calculate the number of staff required to meet people's individual needs. Staff were visible throughout the inspection. They confirmed staffing levels had improved and were adequate for the current number of residents.
●The provider and manager were proactively addressing any issues with staffing through improved sickness management and disciplinary processes where required. Staff were positive about this saying, "It feels like we are in a different place. We will keep going forward now. Staffing is better and sickness managed better."

Systems and processes to safeguard people from the risk of abuse
● There were effective systems in place to protect people from abuse and avoidable harm.
● Safeguarding concerns had been escalated appropriately and action taken to keep people safe when required.
●Staff undertook training in how to recognise and report abuse. Staff told us they would have no hesitation in reporting any concerns to the manager or appropriate authorities, and were confident that action would be taken to protect people.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
●The service had supported visiting as far as possible throughout the pandemic and lockdowns. A relative told us, "Good action during Covid. They had the right balance of seeing and not seeing residents, doing good and being safe."
●Testing facilities were available for visitors and PPE provided. The provider kept people and their families informed and up to date in relation to outbreaks at the home and changing government guidelines.

Relatives confirmed, "The home was pretty good at taking positive action during Covid. We took tests and followed procedures" and, "We are kept in touch with the Covid rules as they change through social media, and by phone."

Learning lessons when things go wrong

● Lessons were learnt when things went wrong. For example, any safety concerns were discussed at the daily stand up meetings, with clarity about staff responsibilities and expectations going forward.

● There were systems in place to capture relevant information from incidents and ensure action was taken to minimise recurrence. The information was added to a risk register. This was frequently updated and analysed by the provider and manager to identify any trends or wider actions necessary to minimise future risks.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for 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
At our last three inspections we found systems to monitor the quality of the service were not fully established or embedded. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of this regulation. However, further improvements were required.

- A new manager was in post, and in the process of registering with the CQC. This was the third such appointment at the service in two years, the previous two having been unsuccessful.
- The new manager was introducing a clear structure with more effective monitoring and accountability, however these changes had yet to be fully established and embedded. They told us, "I feel the home is safe and well led now. It wasn't three weeks ago, but we are getting the systems and processes in place."
- The manager had taken ownership of all aspects of the service, including recruitment and training, to ensure they had complete oversight and responsibility.
- The manager completed daily manager walk arounds and unannounced spot checks to observe staff practice and speak to people using the service. Any ongoing risks were mitigated because the manager was already aware and acting to address the concerns,
- Communication had improved across the service with daily management and clinical risk meetings; and regular meetings for all staff. A member of staff told us, "There is good information sharing. It feels more structured. You know what you are dealing with."
- The manager had introduced systems to provide clarity to staff about their role and expectations. For example, task checklists had been introduced for the manager role; team leaders and care staff with daily oversight by manager. This ensured all key tasks were completed and people were safe. Staff told us, "The care team is working well. Everyone feels like they are getting somewhere. We have real core staff who are really good at their jobs."
- Since the last inspection the provider had been working to ensure the quality and safety of the service through improved governance. They had commissioned an external consultant to carry out quality monitoring visits. This support was ongoing.
- A monthly schedule of audits was being developed looking at all aspects of the service. This included a documented audit by the provider.
- Information from governance processes was reviewed at a monthly governance meeting and informed the home development plan. The provider acknowledged progress had been slow due to Covid, staffing issues and failings in leadership. It was now gaining traction however, and progress was being made.

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 our last inspection the provider had failed to meet their regulatory requirements to provide us with statutory notifications. This was a repeated breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection we found there had been improvements and the provider was no longer in breach of this regulation.
●The provider had notified CQC about any significant events at the service. We use this information to monitor the service and ensure they respond appropriately to keep people safe.
● The manager and provider were open about the previous failings at the service, the work they were doing to address them and where improvements were still required.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
●Overall people and their relatives were positive about the service. One person told us, "The new manager is nice. She will sit and have a chat. Staff are kind. They have never been cross. Nothing could be better." A relative said, "You can't fault the inside it is decorated lovely. They ask residents to choose their own décor which makes it feel like it's their home. Its these things which makes it feel warm and welcoming." Several relatives had attended a lunch to meet the new manager and told us she was approachable, friendly and "she knows the residents when you ask about them."
● Staff spoke highly of the provider and manager and the recent changes to the culture of the service. Comments included, "[Provider] is always supportive and his door always open.", If you have any problems, you can go to [manager]. It's so much better "," The whole atmosphere has changed for the better" and, "[Manager] has made me aware of expectations of the care we are supposed to be giving. All of us staff are looking out for ways to be more person centred."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
●The service's vision and values centred around the people they supported. The organisation's statement of purpose documented a philosophy of maximising people's life choices, encouraging independence and people having a sense of worth and value. Our inspection found that people were encouraged to lead rich and meaningful lives in line with their individual preferences and interests. The manager recognised that accessible communication and staff knowledge of people with a learning disability could be improved, and made a commitment to do so.
●Quality assurance surveys were carried out, and regular meetings were held where people and their relatives could express their views about the service.
●A 'Resident of the Day' programme was in place, focussing on one resident each day. This was an opportunity to review their care and support with them and their family members and gain their views.
●Staff were in the process of finding out as much as they could about people's background and interests, when they could not easily articulate that for themselves. A relative told us, "We are now working on a more in-depth plan involving what Dad's about, his history and his likes and dislikes." This would potentially improve communication and understanding, enabling staff to provide truly person-centred care.
●The provider had introduced a 'You said, we did' board, so that people and staff could see what action had been taken in response to their feedback.
●Overall relatives were extremely positive about their communication with the home in relation to their family member. They told us they had contributed to their care plan and been kept informed about their well-being. They valued being able to access the 'relatives gateway', and view the support being given to their family member in real time.
●Relatives had been supported to maintain their involvement with the service during lockdowns due to

Covid 19. There had been online relatives' meetings, and regular updates by the provider on social media. One relative told us, "They are encouraged to do activities and it was lovely to see residents getting involved in activities via social media during Covid. I could not have done without that."

●Staff had a voice in the running of the service. They were asked for their views in a staff survey, and there were regular staff meetings. They told us they felt listened to and valued. One member of staff said the manager had, "given me so much guidance. I feel really well supported."

Working in partnership with others

●Since the last inspection the provider had continued to work effectively with the local authority quality assurance and improvement team. (QAIT). They shared the minutes of the QAIT visits, which showed how the provider had taken on board the recommendations made and used them to improve the service.

Continuous learning and improving care

●Both the provider and manager emphasised the importance of reflection and continuous learning, in order to improve the care provided. With the support of QAIT and the external consultant, they had recognised the previous failings in the service and worked systematically to address them. They told us the changes being put into place needed driving forward under strong leadership. They were optimistic this would succeed under the new manager, with the support of the provider.