Loxley Health Care Limited

Langtree Park

Inspection report

Oxford Street
Castleford
West Yorkshire
WF10 5DF

Tel: 01977668448
Website: www.orchardcarehomes.com

Date of inspection visit:
13 April 2016
19 April 2016

Date of publication:
20 May 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 inspection took place on 13 and 19 April 2016. The service was previously inspected on 26 and 3 March 2015 but was taken over by a new registered provider in November 2015. Therefore this service will receive a new rating.

Langtree Park Nursing Home provides accommodation and nursing care for up to 60 older people some of whom may be living with dementia and other mental illnesses. There were 37 people living at the home on the day of our inspection. The accommodation is arranged over two floors with the dementia unit on the first floor and the nursing unit on the ground floor. There is a passenger lift operating between the two floors.

There was a registered manager for this service but they were not working at the service providing day to day support. There was an acting manager who had applied to be registered as the 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.

Staff had received training in how to keep people safe. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any safeguarding incidents.

There had been an issue with a high use of temporary staff at the service, but they had recently recruited to all care staff posts and were in the process of recruiting to the vacant nursing posts.

Risk in some areas such as pressure management was well recorded. Risks around the use of assistive equipment such as wheelchairs, bathing equipment, shower chairs and specialist seating systems was not always recorded to ensure identified risks were reduced to the lowest possible level.

We found some medicines were on the whole stored and administered safely. However, we did find some examples of poor practice. This included around the administration of covert medicines to four people which was not in accordance with the Mental Capacity Act 2005. This breached the regulation around safe care and treatment.

We found detailed capacity assessments had been carried out for people living in the dementia unit which were compliant with the Mental Capacity Act 2005. Deprivation of Liberty Safeguards had been appropriately applied for and authorisations were in place or awaiting authorisation by the relevant body.

People were supported to eat their meals by care staff appropriately and sensitively and people told us how much they enjoyed their meals. People's nutritional and hydration needs were met, although this was not

always recorded in detail. However, the service was in the process of making improvements in this area.

We found all the staff to be caring in their approach to the people who lived there and treated people with dignity and respect. We observed staff to be kind and compassionate throughout our inspection.

People were offered choice in how they wanted to be supported and families felt involved in the care provided to their relatives. The service was in the process of transferring care files to the registered provider's system of recording. We found some had been completed well and detailed each area of people's support needs. Work was on-going to ensure all care plans were updated as not all the care plans we looked at were fully completed.

Complaints were handled appropriately and people were happy that any concerns raised had been acted upon.

The home had recently been taken over by a new registered provider. As a result the home had received intense support from the operations manager and an acting manager who were providing strong and present leadership and management support to the service. Improvements were evident but it was too early to determine whether these improvements would be sustained.

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

Staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents

Risk assessments were detailed to reduce some risks but not all risks had been identified with risk reduction plans in place to ensure risks were reduced to an acceptable level.

Medicines had not always been administered in line with good practice and the Mental Capacity Act 2005.

Is the service effective?

Requires Improvement

The service was not always effective

Deprivation of Liberty Safeguards (DoLS) applications had been made appropriately to comply with the Mental Capacity Act 2005.

We found detailed mental capacity assessments on the dementia unit which complied with the Mental Capacity Act 2005 and this process was to be extended to the nursing unit to ensure compliance with the Act.

People told us how much they enjoyed the food and they were offered choice at mealtimes.

Is the service caring?

Good

The service was caring

We found staff to be caring and compassionate towards people using the service and they knew how to ensure privacy, dignity and confidentiality were protected at all times.

People were encouraged to maintain their independence around activities of daily living and with their mobility.

The service used informal advocacy and formal advocacy

services when required to ensure people had a voice.

Is the service responsive?

Requires Improvement

The service was not always responsive

The service was in the process of changing all new care plans to the registered provider's paperwork. Some had been completed in detail but not all had been fully completed. People's care needs were regularly reviewed to ensure changing needs were identified and responded to.

The service provided activities that were meaningful to the people using the service and people and their relatives spoke highly of the activities coordinators.

People and their relatives knew how to complain and were confident their complaints would be resolved.

Is the service well-led?

Requires Improvement

The service was not always well led

There was a new management structure in place that was providing clear and evident leadership. However, it was too early to determine whether the changes implemented would be sustained.

There were clear values that included compassion, dignity, and respect. The management were working hard to embed a positive culture at the home, and embed best working practices amongst staff.

The service had utilised a high level of agency staff but the management had worked hard to recruit new staff to ensure a motivated and consistent workforce.

Langtree Park

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 19 April 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors and a specialist advisor with expertise in dementia care.

The registered provided had not been asked to complete 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. We contacted the local authority contracts and safeguarding departments to gather recent information about this service to inform the inspection process.

We observed the breakfast and the lunch time meal experience in both units and the activities programme in each unit. We spoke with the operations manager, the acting manager, two nurses, two agency nurses, three care workers and the cook as part of our inspection process. We reviewed the case files of nine people living at the service. We spoke with seven people who used the service, and six relatives who were visiting at the time of our inspection.

We looked at a variety of documents which related to the management of the service including environmental and quality audits.

Requires Improvement

Is the service safe?

Our findings

People who were able to speak with us told us they were safe at Langtree Park. One person told us "Yes, I feel safe. If there was a carer I didn't like, I would report it. I would tell them." One relative said their relation was, "Very safe and secure" and was "thriving" since going to live at Langtree Park. Another relative told us their relation was "Better now than they have been for ten years." They told us they were confident their relative was safe at the home.

We asked people living at Langtree Park and their relatives whether there were enough staff to meet the needs of the people living there. One person said "They could do with more staff. They can't deal with all of us. Some people can't get out of bed and some need feeding in the lounge." Another person said when asked about the response time to their call system, "It's not bad. I think they could do with another one carer. It's hard work." However, one relative we spoke with told us "It's much improved since the new company has taken over."

The operations manager told us the registered provider was launching a new dependency tool on 20 April 2016, which would clearly identify the number of staff required to support the people in both the dementia and nursing units based on their needs. The registered provider currently utlised a dependency tool, and the operations manager told us in addition they determined staffing levels by observations and monitoring of staff and people using the service. We observed people supported on the nursing unit had high dependency needs requiring two staff to support with positioning and personal care. A high number of people were supported to be cared for in bed, which meant on occasions on our first day of inspection we observed staff were unavailable to support people. One person also told us "Sometimes it takes a long time for staff to come when I use my buzzer." We did not observe a delay in the answering of call bells during our inspection.

We asked staff about their understanding of safeguarding. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. One member of staff we spoke with told us if they suspected any type of abuse was happening they would report this immediately to the senior on duty or the manager if necessary. They could tell us what signs of abuse to look for in people who could not communicate verbally, which demonstrated they understood how to recognise abuse.

The service had notified CQC about incidents between people with behaviours that challenged others and the actions they were taking to try to reduce harm to people using the service.
The operations manager told us they regularly observed staff during their daily walk around the service, to see how staff interacted with people who might present with behaviours that could challenge others and offered advice to staff on how to support the person. We found the service was recording accidents and incidents but these were not always fully investigated or actions recorded to prevent a reoccurrence.

We reviewed the risk assessments in place for people using the service. We found there was a lack of risk assessments around the use of assistive equipment such as the bath hoist, wheelchairs and commodes in

all the files we looked at. We also found in some files, there was conflicting information in the moving and handling assessment and care plans which meant staff did not have clear guidelines to follow. We did not observe any poor moving and handling practice during our inspection, but the lack of documentation did not support good practice. There were areas of good practice and people who were supported to eat whilst in bed had a photograph on their wall detailing the angle they should be positioned at to safely be supported to eat. However, we did see one occasion this was not followed and on another, we noted a person at risk of choking had a thickened drink left in reach whilst not being supervised. We brought this to the attention of the operations manager.

We inspected medicines storage facilities at the home. We found the fridge and medicines storage area temperatures were taken daily and were consistently within an acceptable range. All medication was supplied in a monitored dosage system and allergies or known drug reactions were clearly annotated on each person's medicine records and the MAR sheets. Stock was securely stored in the clinical room before being transferred to the medication trolleys. Medicines were administered to people by appropriately trained nursing and care staff and their competencies had been checked.

Some prescription medicines contained drugs that were controlled under the misuse of drugs legislation. These medicines were called controlled medicines. We saw controlled drug records were accurately maintained. The administration of the medicine and the balance remaining was checked by two appropriately trained staff.

We looked at the provider's medicines policy which had recently been reviewed. The policy demonstrated the provider had taken steps to ensure they complied with current legislation and best practice in the administration of medicines. The registered provider had compiled protocols for the administration of certain medicines which required specific rules to be observed. For example, we saw protocols were available for the administration of warfarin where the dose is determined by periodic blood tests. We saw the most current blood test results were available for care staff to refer to. We carried out an audit from a random sample of seven medicines dispensed in boxes or bottles to account for their use or accuracy of recording. On all occasions the stock levels were accurately recorded. We saw an assessment was undertaken to assess people's ability to self-medicate taking into account mental capacity, manual dexterity and personal choice and the operational manager told us no one living at the home was self-medicating at the time of our inspection.

We saw one person was on continuous oxygen therapy. Appropriate signage was being deployed to make staff and visitors aware of the use of oxygen and the safety requirements which must apply.

During the morning we observed a nurse administering medicines on the nursing unit and had some minor concerns around the administration of medicines. For example, we observed the administration of one person's medicines after breakfast when the instructions stated the medicines were to administer 30 to 60 minutes before food. We also saw some people were prescribed Thick-and-Easy. However whilst the product was dispensed on an individual basis the nurse administered the preparation to all people from one person's supply. We found 'as necessary' (PRN) medicines were not consistently being supported by written protocols which described situations and presentations where PRN medicines could be given.

The provider's policy indicated hand-written MAR sheets should be signed by two staff. We found this not to be consistently applied and some medicines were mis-spelled. We saw that whilst some liquid preparation, creams and eye drops had been recorded with the date of opening, this was not always the case. In one example, the medicine label of the opened product clearly indicated this medicine should be discarded four weeks after opening. The MAR sheet gave an indication it was likely this medicine was being administered

outside a four week period after opening. We also found bottles of medicines were not always dated upon opening and in once case the bottle was heavily stained which made the label unclear.

During our inspection of medicines we became aware of four people receiving their medicines covertly. When it is agreed to be in a person's best interests, the arrangements for giving medicines covertly must be in accordance with the Mental Capacity Act 2005. Our observation of administration, scrutiny of care plans and subsequent discussion with the operations manager showed a robust legal framework did not exist to allow medicines to be legally and safely administered. The pharmacist had not been engaged to give advice on a method of disguising the medicine nor whether medicines could safely be crushed or added to food. We saw no evidence of prescribed medicines in tablet form being considered to be dispensed in liquid form. A care worker who administered medicines told us, "I add the medicine to whatever food is being eaten". We saw some evidence a best interest meeting had taken place before a decision to administer medicines covertly but no outcome of the meeting was recorded. We saw no evidence of which medicines were being considered to be administered covertly. We saw no planned approach to review the decision. The operations manager told us they would take speedy action to remedy the matter and by the second inspection date, the service had initiated a meeting with the pharmacist to ensure the correct process was followed.

The examples above evidence the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment

We looked at the records for three recently recruited staff. We found recruitment practices were robust and each staff member had undergone pre-employment checks before they started work at the home. Each record showed detail of the person's application, interview and references. Each person had undergone a Disclosure and Barring Service (DBS) before they started work at the home. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. The operational manager told us they had recruited into all the care positions, but were still waiting for new staff to start work. They were still trying to recruit to two vacant nursing posts.

We had no concerns regarding the cleanliness at the service and staff were observed to follow good infection control practices. We found the environment was well maintained and documentation confirmed regular checks were carried out on the environmental systems which meant people were cared for in a suitably maintained environment.

Requires Improvement

Is the service effective?

Our findings

As part of our inspection process we looked to see how the service was supporting staff to develop knowledge and skills to provide a high quality service. The operations manager told us the service was in the process of incorporating the registered provider's blended learning system for all staff. They told ust training was not all up to date but all training had been booked in and they predicted over 90% of staff would be up to date with all the required training in the following month from the inspection. The operations and acting manager were in the process of undertaking supervision with all staff to ensure they understood how the system worked and staff could access the programme to commence learning. They explained staff would do their theory 'on line' followed by practical's and workshops with a training executive. The training executives would observe practice to ensure staff had understood the learning. They added, this style of learning was aimed at ensuring staff had both the knowledge and the skills to provide support to meet people's needs. In addition the manager and deputy manager would receive specialist dementia training to ensure the staff at the service provided up to date care in line with best practice in dementia care.

One member of staff told us the service was supporting them to develop by providing training and development opportunities. For example, they were to commence a National Vocational Qualification in care as they had expressed an ambition to be a senior carer. They told us they had been encouraged to progress and were being supported in this process. Staff require supervision to be supported to develop in their roles and so that any gaps in knowledge and skills can be identified through this process to ensure safe care delivery. The operational manager told us supervisions had taken place but they would be more individualised and specific to the individual member of staff going forwards.

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. We found the operations manager had completed capacity assessments for people living on the dementia unit and these were to a high standard and decision specific. They were in the process of ensuring best interest decisions were made and recorded. We saw evidence they had written to all relatives for confirmation of Lasting Powers of Attorney or Guardianship to ensure the service was seeking consent from relatives in line with the legislation. They had not yet completed all the required capacity assessments on the nursing unit as they had prioritised the assessments first for people they had assessed as lacking capacity in specific decision making.

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 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 operations manager told us seven people were subject to an authorised Deprivation of Liberty Safeguards with a further 12 authorisations awaiting consideration by the supervisory body. We looked at

four of the seven granted application to review the actioning of any condition which may apply. We found on some occasions the conditions attached to Deprivation of Liberty Safeguards had been translated into care plans and were being applied. However in one instance the condition was not effectively being applied. On this occasion the condition required the decision to administer medicines covertly to be reviewed by the managing authority. The operations manager responded to this immediately and by the second day of inspection had organised a meeting with the pharmacist to ensure the service was meeting the requirements of the Mental Capacity Act.

We saw the provider's restraint policy promoted a restraint free approach to care which recognised restraint as a last resort after exhausting all reasonable alternative management options. We looked at a sample of care plans for people who we saw had bed-rails attached to their beds. Assessments of people's needs demonstrated bed rails were used only to prevent people falling out of bed or where people were anxious about doing so. We saw families had been included in discussions prior to bed-rails been used. We saw risk assessments were carried out to ensure the potential risks of using bed rails were balanced against the anticipated benefits to the user. We concluded that a robust system of bed-rail evaluation and assessment existed in the home.
We saw there was compatibility between the bed, mattress and bed-rail to prevent serious injuries from ill-fitting appliances.

We observed the breakfast and lunch time meal experience on both units. Tables were nicely laid out with table cloths, cutlery and condiments. People were offered a choice of meal options and they told us they enjoyed the food served at the home. The service had recently changed from having the main meal of the day at lunchtime to evening as the registered provider was undertaking a trial to see if this increased people's appetites and improved sleep patterns. One relative told us they thought this was a good idea as their relation was not often hungry at lunch time following a large breakfast.

We spoke with the chef who told us they were in the process of purchasing moulds to make the soft diets look more appealing to people using the service. They told us the menus were determined by the registered provider but they ensured people were provided with meals they enjoyed. The registered provider employed a food and beverage manager who would be working wth the home to ensure excellence in the provision of nutritional and appetising meals. This meant the service was prioritising the importance of good food and hyradation to ensure the wellbeing of the people living there.

We observed breakfast on the dementia unit lacked organisation and direction. People were waiting for breakfast which had not arrived by 10 am and we observed some people becoming agitated at the long wait. They were telling the staff they were hungry and thirsty. Once breakfast arrived it was a full cooked breakfast and people enjoyed the food. On the nursing unit many people were assisted to eat and we observed staff undertake this discreetly and sensitively.

We saw evidence in written records that staff had worked with various agencies and made sure that people accessed other health and social care services in cases of emergency, or when people's needs had changed. This had included GP's, hospital consultants, and community nurses, specialist nurses in the field of tissue viability, speech and language therapists and dentists.

The operations manager told us the home was in the process of implementing the registered provider's dementia strategy on the dementia unit. As part of this strategy there would be themed areas and activities areas along each corridor plus specific therapies such as doll therapy. The communal lounge and dining areas would be designed for people living with dementia. Signage would also be improved at the service.

The decorators were at the home on both days of our inspection and the improvements were still in progress. There were also plans to install a kitchenette in the communal areas to encourage people who used the service to be involved in preparing drinks and snacks.

Good

Is the service caring?

Our findings

One relative we spoke with described the care staff as "kind, sensitive to [relatives] needs, and respectful." Another relative told us staff who had been in the service for a long time, knew the people they supported well and their ways provided a caring service. A member of staff told us "You have to care to be a carer. I can tell the residents are well looked after from their body language and facial expressions." People and their relatives told us they had concerns about the high turnover of staff and temporary staff usage, but they were looking forward to more stability amongst the staff.

We found people's needs were assessed and their care and treatment was planned and delivered in line with their individual care plan. People were very comfortable, well dressed and clean, which demonstrated staff took time to assist people with their personal care needs. One person told us, "I really like it here, nothing is too much trouble".

Staff told us they always ensured privacy and dignity was maintained by closing doors when undertaking care, closing curtains and covering people to protect their modesty. We observed staff respecting people's privacy, dignity and human rights. For example, staff asked people's permission and provided clear explanations before and when assisting people with medicines and personal care. This showed people were treated with respect and were provided with the opportunity to refuse or consent to their care and or treatment.

Staff told us they maximised people's independence by encouraging them to continue to undertake personal care tasks such as washing and dressing. Care plans recorded what each person could do independently and identified areas where the person required support. One member of staff told us how they were encouraging one person to improve their ability to walk after a recent decline in this ability

People's bedrooms were personalised and contained pictures, ornaments and the things each person wanted in their bed room. People told us they could spend time in their room if they did not want to join other people in the communal areas. We saw when people chose to spend their day in their room staff took time to ensure they were not isolated.

People were supported to have their spiritual and cultural needs met whilst at the service and this information was recorded in their care plans. One person told us a vicar had been to see them earlier that day. The cook told us all the meat served at the home met Halal requirements.

Whilst all people at the home had the support of families and friends our discussion with the operations manager showed they had a good insight into the requirements to provide unsupported people with lay advocacy.

We reviewed a random sample of four care plans which recorded whether someone had made an advanced

decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff that knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital to ensure the decision whether or not to resuscitated was complied with, if necessary.

Requires Improvement

Is the service responsive?

Our findings

The service was in the process of transferring all care records to the new registered provider's paperwork. This meant the information in the care files we looked at was current and we could see the care plans were evaluated monthly. Some information such as mental capacity assessments and consent was still to be completed on the nursing unit, and best interest meetings and decisions were planned for the dementia unit.

Some files had been completed well and in these files, each area of people's support needs was underpinned by a risk assessment. One person had been assessed as being at high risk of developing pressure sores. The risk assessment had been underpinned by a professional assessment by a specialist nurse. We saw the care plan identified a number of actions required to mitigate the risks. These included the use of a pressure-relieving mattress. Our observations of care and records of care delivery confirmed care was being delivered in a manner which reduced risk to vulnerable people. We saw the outcomes of these assessments were kept under constant review. Work was ongoing to ensure all care plans were updated to the new registered provider's standard as not all the care plans we looked at were fully completed.

The home employed two activities coordinators (pink ladies) to provide a programme of activities for the people living at Langtree Park. Throughout our inspection, we saw people who wanted to be were engaged in activities that were meaningful to them. Not everyone wanted to join in and one person told us they "were happy in their room with their books, and magazines." The home was busy preparing for the Queen's 90th birthday celebrations and the service had involved local firms in a raffle to raise funds for further activities. Relatives spoke highly of the activities provided at the home. One relative said "There's always something going on." and their relation was a "people' person and likes a lot of people around."

People told us they were offered choice in their daily routine. This included what time they wanted to get up and go to bed. One relative told us their relation did not like to get up early and they were able to stay in? bed. One member of staff we spoke with told us "Everyone gets offered a shower or bath every day. For those who don't have capacity we will look to see when they last had one. Sometimes if you run the bath water they will choose to have one. If they go in and say no, then we will support them with a strip wash." The operations manager told us the cook goes round each morning to find out what people would prefer to eat. They were encouraging care staff to offer again at the meal time, to ensure people who might not remember what they had chosen, were free to choose again. We did not always see choice recorded in people's daily records although we observed this throughout our inspection.

People we spoke with knew how to make a complaint and who to go to if they had any concerns. Relatives told us they knew who to go to if they made a complaint and they felt these would be acted upon although they told us they had not had the need to complain about the service. The service had a complaints procedure and we reviewed a recent complaint and how the service had resolved this to the satisfaction of the complainant. This showed there was an effective procedure in place for dealing with formal complaints.

Requires Improvement

Is the service well-led?

Our findings

The home had recently been taken over by a new registered provider. As a result the home had received intense support from an operations manager and an acting manager who were providing strong and present leadership and management support to the service. Improvements were evident but it was too early to determine whether these improvements would be sustained.

There was a registered manager for this service but they were no longer at the service. The acting manager was in the process of registering and they were present at the service during the week. The operations manager was supporting the acting manager twice a week . The operations manager was open and honest with the inspection team about the standard of care provision and had a clear vision and time frame to make and sustain improvements at the service. They were able to evidence the significant improvements that had been made at the service in the short time they had been at the service and were fully aware improvements needed to be sustained.

Staff we spoke with told us there had been many changes but spoke highly of the operations manager and the acting manager, and of their support with training and development. One member of staff told us management were "Fantastic. If I have a question they will answer it straight away. They are very supportive." We also heard "I love working here. I love the residents. It's good team working."

The operations manager told us there had been a recent high turnover of staff and use of temporary staff but they had fully recruited to all vacant care staff positions and were in the process of recruiting nursing staff. They told us they were actively utilising the registered providers disciplinary procedures to ensure the staff at the home met the registered provider's standard of quality and all staff shared the vision of the organisation.

The operations manager shared their vision for the service. They wanted the service to be fully staffed with their own staff providing an exceptional quality of care. They were aiming to be outstanding. They told us they operated an open door policy and encouraged all staff to discuss any issues. They described themselves as open, honest and approachable. Their vision included moving staff away from providing task orientated care to person centred care. They were encouraging good practice by implementing daily stand up meetings with staff. At these sessions they discussed areas the home needed to improve on such as increasing people's fluid intake, including the monitoring and recording system, and management oversight of this aspect of the service provision. They had also implemented resident of the day where one resident on each unit would have a full care plan evaluation by the nurse or senior and a deep clean of their bedroom and ensuite and any issues found with the environment would be actioned by the handyman that day. This was in addition to the usual process of audit and monitoring of the service provided but meant that all aspects of a person's care and daily life would be intensly reviewed three times each year.

The service had been utilising a high level of temporary staff which had not provided consistency of care. However, they were at a point where all care staff had been recruited and they could evidence the reduction in temporary staff going forwards.

The service was holding regular team meetings. We were shown the minutes of the latest meetings which demonstrated the service was involving staff in its development. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service.
The operations manager told us they would be introducing a weekly staff memo to ensure staff were kept fully informed. The service was in the process of introducing regular supervisions, appraisals, and training and development following an audit of the position following the changeover of registered provider.

We looked at an audit of medicines undertaken the week before our inspection by one of the nursing staff. This had identified hand written MAR charts were not being signed by two staff and the action recorded was to remedy the issue with immediate effect. We found the issue had not been remedied as the errors were still present at our inspection. The audit found eye-drops were not dated and within an expiry date. We found the issue still remained. The audit had identified bottles of liquid medicines were not clean with the result the label was unclear; our observations showed the condition remained. We raised this with the operations manager who told us they had not yet signed off the audit as it had only occurred the week before the inspection. However, these actions could have been completed prior to the sign off by the operations manager by the person who had undertaken the audit so they could have been remedied immediately.

We saw the operations manager had completed a quality monitoring report in February 2016 and had completed a thorough audit of the service provided against CQC 'safe' key line of enquiry. This detailed the actions required and the time frame for completion and when actions had been completed. They told us there audit would consist of observations "on the floor, review of medicines administration records, observing the meal time experience, speaking with residents and staff and from this information they would set an action plan for the registered manager to complete and check the following month that actions have been completed.

The operations manager advised a compliance officer employed by the registered provider would undertake a compliance check at each home. The frequency of these registered provider audits. would depend on the homes level of compliance. If they found the home to be inadequate they would return within a month, and if required improvement it would be every three months and if fully compliant these would be at a six month interval. This showed us the registered provider was monitoring the quality of the service provided at the home.

We observed copies of the registered provider's newsletter were readily available in the entrance of the home. This showcased recent events at Langtree Park and also provided information from the registered provider to keep people informed about the service provided.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments and risk reduction measures were not in place for assistive equipment. We found some issues around the administering of medicines including covert medicines, which did not comply with the Mental Capacity Act 2005 and the NICE good practice guidelines.