Langley Court Rest Home Limited

Langley Court Rest Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 17 October 2014 and was unannounced. At the last inspection on 9 October 2013 we found the service to be meeting the regulations we looked at.

Langley Court Rest Home provides accommodation and personal care for up to 28 older people, many of whom live with dementia. On the day of our visit there were 20 people living in the home.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Care plans and risk assessments were not always in place with regards to risks, such as risk of choking and pressure ulcer prevention and management.

Medicines, including controlled drugs were not always stored or administered safely.

Summary of findings

Risks relating to the premises were generally well managed. However, people who required supervision when in the community were at risk of coming to harm as they were able to leave via a fire door without staff being aware.

The service had responded appropriately to allegations of abuse and staff had a good understanding of how to recognise abuse and how to help protect people from the risk of abuse or harm.

There were enough staff employed to meet people's needs. Recruitment procedures ensured that only people who were deemed suitable worked within the home. Staff were provided with support and training to help them to carry out their roles. Staff had effective induction, support and training.

Accidents and incidents were reviewed to identify patterns and prevent these from happening again.

Staff had a good understanding of the Mental Capacity Act 2005 and their responsibilities under this, with clear policies in place. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. People's rights in relation to this were therefore properly recognised, respected and promoted.

People were provided with a choice of food and were supported to eat when required. The service supported people who were at risk of malnutrition and those with specialist needs related to their diet. People were supported effectively with their health needs and in accessing health professionals.

Staff had a good knowledge and understanding of people's individual needs and preferences.

They treated people with kindness and compassion, dignity and respect and people were involved in decisions about their care.

A range of activities was offered to people using the service. People were supported to meet their religious and cultural needs.

People using the service, relatives and staff were encouraged to give feedback on the service and raise issues of concern. People knew how to make complaints and there was an effective complaints management system in place.

CQC registration requirements, including the submission of notifications in relation to safeguarding and applications to deprive people of their liberty and their outcomes had been met.

At this inspection, there were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to care and welfare of people and medicines management. Although there were some quality control systems in place, the provider had not identified these issues. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 safe. Where people were at risk of choking and developing pressure ulcers, care plans and risk assessments were not always in place. Medicines management was unsafe because controlled drugs, were not always managed safely. The premises were generally well managed. However, people who required staff supervision could have left the home through an unrestricted and unmonitored fire-door. Staff had a good understanding of how to recognise signs of abuse and the action to take to safeguard people. Staffing numbers were sufficient to meet people's needs and recruitment procedures were robust to ensure that only people who were deemed suitable worked within the home.	**Requires Improvement**
Is the service effective? The service was effective. Staff received induction, support and training to ensure they could carry out their role effectively. Staff were aware of the Codes of Practice in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). This helped to ensure people's rights in relation were properly recognised, respected and promoted. People were supported to eat when necessary and were provided a choice of food and drink. People at risk of malnutrition and those with specialist dietary needs were supported effectively. People had access to health professionals to support them to meet their needs.	**Good**
Is the service caring? The service was caring. Staff knew people's individual needs and preferences and treated people with kindness, compassion, dignity and respect. People were involved in decisions about their care.	**Good**
Is the service responsive? The service was responsive. A range of activities was offered.People were supported to meet their religious and cultural needs. People using the service and their relatives were encouraged to give feedback on the service and there was an effective complaints system in place.	**Good**
Is the service well-led? The service was not always well-led. Although there were some audits in place they had not picked up the issues we found in relation to care planning, medicines management and safety of the premises.	**Requires Improvement**

Summary of findings

The manager was open and transparent, and people using the service, their relatives and staff told us that the managers were approachable and listened to them. The home had submitted notifications to CQC regarding significant incidents as required.

Care Quality Commission

Langley Court Rest Home

Detailed findings

Background to this inspection

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

This inspection took place on 17 October 2014 and was unannounced. It was undertaken by an adult social care 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.

Before our inspection we asked the provider to complete a Provider Information Return (PIR). The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what they could do better and improvements they plan to make. We reviewed this, as well as other information we held about the service and the provider. We also contacted the local authority commissioning and the safeguarding team and the local GP to ask them about their experiences of the service provided to people.

During the inspection we observed how staff interacted with the people who used the service. We also 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 spoke with four people who used the service and two relatives. We also spoke with the director, the registered manager, the deputy manager and five other members of staff. We looked at six people's care records, five staff recruitment files and records relating to the management of the service including quality audits.

Requires Improvement

Is the service safe?

Our findings

People's care was not always planned in response to their needs. Two people had been assessed by a speech and language therapist (SLT) as being at risk of choking when eating. There was guidance in the kitchen in relation to how food should be prepared for them to reduce this risk. However, there were no choking risk assessments or care plans in place which were regularly reviewed and updated. This meant people may have been at risk from inappropriate care planning.

The manager told us that no one had care plans or risk assessments in place in relation to pressure ulcer prevention or management. However, there were indications that several people were at risk of developing pressure ulcers. For example, many people had been provided with pressure relieving cushions to sit on and two had been provided with pressure relieving air-mattresses. One person was seen regularly by the tissue viability nurse and spent all of their time in bed. This meant that the manager was not assessing and monitoring the risk of people developing pressure ulcers to ensure the necessary controls were in place.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found the storage requirements of a controlled drug were not being met as the staff had not identified it was a controlled drug. This meant they were unaware of their responsibilities in relation to this. Controlled drugs are medicines which have strict legal controls, according to the Misuse of Drugs Act, to prevent them being misused, obtained illegally or causing harm. When we made the manager aware of the controlled drug they made immediate arrangements to ensure the storage met legal requirements.

We found that the manager was not following guidance from the Royal Pharmaceutical Society of Great Britain (RPSGB) in "The Handling of Medicines in Social Care" in relation to the management of controlled drugs. The guidance suggests that care homes have additional controls in place to prevent misuse and to make sure controlled drugs are managed appropriately and safely. For example, the RPSGB states that, "In residential settings it is good practice if a second appropriately trained member of staff witnesses [the administration of controlled drugs]", and that "Residential social care settings for adults should keep a separate record of the receipt, administration and disposal of CDs" in a controlled drugs record book. The manager confirmed this was not happening as they had not identified they were administering a controlled drug.

We checked stocks for five medicines with staff and for one medicine there was one less tablet in stock than expected. This indicated that one person might not have received one of their medicines as records indicated.

We observed staff administer medicines and saw that, for one, when they came to sign the Medicines Administration Record (MAR), it had already been signed. Staff told us they had signed it in error before it was administered and told us this was not usual practice. They then wrote the actual time they administered the medicine on the MAR for reference.

One person was prescribed a medicine to be given as required (PRN) when they became anxious. The staff member we spoke with knew the signs the person usually displayed when they were anxious and the occasions when they would benefit from this medicine. The staff member also told us about the dose of the medicine they would administer to the person. However, there was no written guidance for staff to follow which set out this information for other staff to follow. This meant there were risks that the person might not receive the right dose of medicine to manage their condition.

These issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw evidence of people's current medicines on their MAR and records of medicines received into the service. We found people's allergy status was recorded to prevent inappropriate prescribing. Staff received regular training in medicines administration.

Risks in relation to the health and safety of the premises were generally well managed. However, there was unsecured and unmonitored access to a fire-escape leading to the car park through a fire door. As many people using the service were living with dementia and were disorientated to time and place, there was a risk that people could leave the home via this door and come to harm while staff were unaware of their whereabouts.

Requires Improvement

Is the service safe?

A risk assessment was in place to reduce the risks of Legionella developing in the water system. Legionella is a bacterium which can accumulate rapidly in hot water systems if control mechanisms are not in place. A checking and maintenance programme was in place for various items of equipment in the home including the lifts, call bells, hoists, slings and fire-fighting equipment to ensure they were safe.

People told us they felt safe. The service had responded appropriately to allegations of abuse. Staff told us they received training in safeguarding adults as part of the induction and annually. Staff we spoke with had a good understanding of how to recognise abuse, and what to do to protect people if they suspected abuse was taking place.

People using the service, relatives, staff and managers told us that the staffing levels met the needs of the people using the service and we observed there were enough staff on shift. We looked at the recruitment records for five staff members. Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised at the service to reduce the risks of people being cared for by unsuitable staff.

Procedures to evacuate the home in the event of an emergency were in place. Each person had a Personal Emergency Evacuation Plan (PEEPs) to identify how each person would be supported to leave the service in the event of an emergency.

We found accidents and incidents were recorded in a way to facilitate their analysis, such as the time and location incidents occurred. Staff had recently identified that a person was regularly falling in their bedroom. This resulted in the manager putting processes in place to increase support provided to this person to manage this risk. Staff were aware of incident reporting processes and escalated concerns to the registered manager or director as required.

Good

Is the service effective?

Our findings

People made positive comments about the food including, "The food is nice" and, "I'm happy enough with the food". However, one person commented that they were regularly served soup from a packet, which they did not enjoy. The manager confirmed that packet soup was often served in the evenings, but they would take on board this feedback and look to provide homemade soups more often.

We saw people were offered a choice of food and drink. Staff spoke with people and explained the choices, giving them enough time to make their decisions. The food served was nutritious and reflected a balanced meal. Staff supported people who required assistance to eat and drink appropriately, taking time and encouraging them to finish their meal. Where a person had a particular cultural dietary requirement they told us staff were aware of this and the food met their needs.

People's weight was monitored regularly, and specialist support was obtained to investigate weight loss when this was a concern. Several people received supplements to help reduce their risk of malnutrition. When staff identified that people had difficulties in swallowing, referrals to SLTs had been made for specialist advice and this was followed.

People told us they had access to health services such as the GP, dentist and optician. Staff understood how to support people to stay healthy. People's care records showed that, when there had been a need, referrals had been made to appropriate health professionals.

New staff underwent a comprehensive induction including training in safeguarding adults from abuse, infection control, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). An external trainer supported new staff to meet Skills for Care's Common Induction Standards. These standards enable care workers to demonstrate their understanding of how to provide high quality care and support. In addition, new staff shadowed experienced staff to learn about the role before they worked unsupervised.

Staff told us they received a suitable level of training to enable them to meet people's needs. One staff member said, "The training is good. It's helpful and handy". Each staff member had a training programme in place. Training included group sessions in topics such as moving and handling, and online courses on other topics. In addition, the manager encouraged and supported staff to do accredited distance learning in topics such as safeguarding, medicines management and English. Staff were also supported to complete vocational qualifications in health and social care. In addition, our discussions with staff and observations of their practices showed they had the necessary skills, knowledge and experience to support people appropriately.

Staff felt supported and had regular one to one meetings (supervision) with their line manager. One staff member said, "[The manager] is a 'pusher'. She encourages us to do a lot of training, and we have a lot of supervisions." Supervision records showed that during the meetings staff had the opportunity to explore their training needs and issues such as how to work best with people using the service.

Our discussions with staff showed they had a good understanding of the principles of obtaining consent and the Mental Capacity Act 2005, having received training in this. For example, staff told us they obtained consent before providing care and support to people. The manager and staff also had a good understanding of their responsibilities in relation to the DoLS. They had recognised that there were circumstances where people were being deprived of their liberty. As a result they had applied for and had obtained authorisations to deprive some people of their liberty, as part of keeping them safe and helping to maintain their rights.

Good

Is the service caring?

Our findings

People using the service and their relatives said staff and the manager were caring. One person told us, "I'm very happy here. Everything is provided. The staff are very nice, very approachable, anything you want they'll do for you." A relative said, "They're all so friendly and so nice…They meet [my relative's] care needs…They talk to him and treat him as an individual, and put their hand on his shoulder. I couldn't find anything to improve it. I couldn't wish for a better place." In a recently received questionnaire one relative had written, "I can't fault the home in any way, it's so homely. I am pleased that [my relative] is so cared for. I am so lucky to have found [my relative] with such caring people." One staff member told us, "The best thing about this home is being with the [people using the service]".

Staff treated people with kindness and compassion. When a person became distressed and started to exhibit a behaviour that challenged the service they reacted appropriately, responding with warmth in a calm way. When a relative did not bring items for a person as planned staff told us, "I'll buy [the item] on my way home" so they would have it the next day.

Staff listened to people and involved them in their care. Each person also had a keyworker who was responsible for meeting with them regularly to check whether they were happy with their care, taking action to address any unmet needs. Staff also used these meetings to encourage people to share their views on their care and to make suggestions to improve the service, and these were passed onto the manager. One staff member told us, "We always involve people. We ask them about what they like. If someone doesn't want to get up then that's fine, we'll leave them as it's their choice." Another staff member said, "I ask people if they would like talc on after a bath. I let them choose their dresses and shoes, and whether they want a cardigan on or not." People's preferences, such as the gender of the person they would like to provide personal care, was recorded in their care plans and staff observed these. Staff asked people what they would like to eat and drink and where in the home they would like to spend their time.

Staff communicated well with people, and understood the needs of people who had difficulties in communicating verbally. Staff demonstrated they understood when people were communicating feeling such as fear or unhappiness and were able to respond to meet people's needs. We saw staff sitting and spending time talking with people throughout the day, using touch to communicate with and soothe people when this was appropriate.

People's dignity and privacy were respected when staff supported them as staff had a good understanding of how to maintain people's dignity. For example, when staff supported people with personal care they ensured doors were closed beforehand. We observed that staff knocked before entering people's rooms, and greeting them as they walked in. When people required assistance with personal care, staff supported them to leave the room with subtlety. The service had asked people whether they had a preference for males or females to provide their personal care and this was documented and respected. We observed, and staff told us, that the manager led by example in providing care in a dignified way, spending much of their time directly caring for people.

Good

Is the service responsive?

Our findings

Some people told us that, although some activities were offered, there were not enough of these to meet their interests on a day-to-day basis. One person told us, “There’s not enough to do. I miss shopping and gardening.” Another commented that there was too much “sitting around.” A third person said they would appreciate going on more outings. A relative commented, “Could they not do a little more with [the people living] here? My [relative] is bored out of [their] mind!” The manager explained that currently there was only a part-time activities officer working which meant activities were limited. However, a full-time activities officer had been recruited and was awaiting clearance to start and would aim to improve on the activities on offer.

Some activities were arranged throughout the week. For example, one person told us they took part in activities such as bingo, quizzes, painting and colouring and we observed a quiz taking place during our inspection. Musicians and local choirs visited the home to entertain people every few months. Recently, a pet therapy service had begun visiting people monthly. Day trips were occasionally planned to local places of interest and staff arranged for birthdays to be celebrated within the home.

People told us their spiritual needs were met and ministers from different churches attended most weeks. Staff told us they would arrange for people to have their spiritual needs met by other churches if necessary. In addition, staff were aware of people’s dietary needs in relation to their culture and provided suitable food where required.

People’s care plans were used to make sure they received care centred on them as an individual. The service carried out assessments of people’s needs before they moved in to make sure they could meet their needs. Care plans showed what was important to people and had information on people’s day and night time routines, hobbies and backgrounds. People and their relatives had been consulted with as part of the care planning process to gather this information. This information about each person was accessible to staff and our discussions with staff showed they had a good knowledge of it.

The service was responsive to the views and suggestions of people using the service and their representatives. The service had recently sought feedback from people and their relatives through an annual survey. One person had requested more fruit and they told us this had been provided. One relative had requested free Wi-Fi and we noted this was being installed. Another person told us how they had requested an additional item for their room and it had been promptly given.

There was a complaints procedure and this was displayed in a communal area so people using the service and their representatives had access to it. People told us they knew how to complain and would do so if necessary.

Requires Improvement

Is the service well-led?

Our findings

Although there were some audits in place they had not picked up the issues we found in relation to care planning and medicines management. The manager was involved directly in writing and reviewing care plans and risk assessments, along with the senior support workers. However, this system had not identified that some necessary care plans and risk assessments were not in place. Records showed that regular stock checks of a small sample of medicines were carried out as a way of monitoring the management of medicines. However, this method of auditing had not identified that a controlled drug was being managed inappropriately. The director often visited the service, however, it was unclear what aspects of the service they checked and there was no record of any audits carried out at these visits, which may have picked up some of these issues. These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The other audits in place helped towards maintaining the quality of care. These included audits of staff recruitment documentation and training which the manager monitored to ensure that staff knowledge and skills were current. In addition, there were regular health and safety audits carried out to make sure the building was well maintained. The quality of care was also monitored through keyworker meetings, staff meetings and supervision, as well as the annual survey of people using the service and their relatives.

People using the service, relatives and staff spoke highly of the manager, saying she was caring, supportive and listened. One resident told us, “I like the manager, she’s very nice.” Another resident said that the manager often comes round and asks what they think of the place, and said the management were “very good.”

The manager understood her role in supporting staff well, working closely with them and providing regular supervision. The manager had cultivated a culture whereby staff felt supported and listened to. Staff were given opportunities to express their views and make suggestions to improve the quality of the service provided to people. Staff told us they enjoyed their jobs and reported high job satisfaction. One staff member said, “I love working here as it’s really friendly and cosy.” Another staff member said, “[The manager] is fantastic, she’s very open to ideas.” Another staff member said, “When we need her she’s there.” Resources were in place to support staff, with the provider investing in frequent staff training which helped staff to understand their roles better.

We saw that the manager was “hands-on” spending a lot of time working directly with people using the service and staff, leading by example. They were open and honest and had a good understanding of their own strengths and weaknesses. The provider had recently created a new post and recruited a deputy manager to support the manager. We saw that the strengths of the manager and deputy complemented each other. The deputy had spent much time improving record keeping, updating policies and procedures and implementing additional health and safety audits. We saw that they had an action plan in place and were on-track with this. The manager told us the deputy had been pivotal in improving the service.

Leadership was visible at all levels. Shifts were organised and overseen by the senior support worker leading each shift. The senior member of staff was responsible for ensuring that care was provided to an appropriate standard. For example, each day they checked the cleanliness of people’s bedrooms and whether staff had made people’s beds and provided oral care. They supervised and supported staff, leading by example, offering support and guidance to less experienced staff. Staff were aware of their own responsibilities. They also had a clear understanding about each other’s roles so they knew know the best person to approach for the issue at hand.

The provider played an active role in the running of the home and the manager described him as supportive. He met with all new staff individually during their induction to offer them support and listen to their views. He was involved in staff meetings and in staff management. The provider had also recently produced the first draft of a newsletter which he planned to send to relatives regularly to update them on issues, activities and events at the home.

The manager encouraged staff, people using the service and relatives to raise issues of concern with them. Staff told us they felt able to raise concerns at any time or during staff meetings and supervision. During our inspection one relative had raised a concern with the manager. We observed that, during the handover, the manager and staff discussed the concern and together they planned the

Requires Improvement

Is the service well-led?

action they would take. The director was involved in investigating staff grievances, holding meetings with the relevant parties to resolve the issues. Staff told us they were happy with the outcome of a recent investigation.

CQC registration requirements, including the submission of notifications in relation to safeguarding and applications to deprive people of their liberty and their outcomes had been met.

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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who used services were not protected against the risks of receiving care and treatment that was inappropriate or unsafe by means of the planning of care to meet people's individual needs and ensure their welfare and safety. Regulation 9(1)(b)(i)(ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who used the service were not protected against the risks associated with an ineffective operation of systems to regularly assess and monitor the quality of the services and to identify, assess and manage risks relating to the health, welfare and safety of people and others who may be at risk from the carrying on of the home. Regulation 10 (1)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who used services and others were not protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the recording, safe keeping and safe administration of medicines. Regulation 13.