Mr Daljit Singh Gill

The Langleys

Inspection report

12 Stoke Green
Coventry
West Midlands
CV3 1AA

Tel: 02476636400

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
The Langleys is a residential care home providing the regulated activity of accommodation for persons who require nursing or personal care up to a maximum of 15 people. The service provides personal care support to older people aged 65 and over. At the time of the inspection the service was providing personal care for 11 people.

People's experience of using this service and what we found
Lessons had not been learned, because the provider continued to fail to ensure people living at The Langleys always received safe, high-quality care. Whilst some improvements to benefit people since our last inspection, progress to implement all the required improvements had not been sufficient. The provider remains in breach of the regulations, and as a result, people remained at risk of harm.

People had individual care plans describing the care and support they needed, but risk management was not clearly demonstrated to show people's needs were met safely and effectively. Infection control practices needed improvement to ensure people were not placed at risk of infection. People's medicines were not always managed safely. Medicine records did not clearly show how medicines had been managed. Staffing arrangements were not clearly demonstrated to show they were effective in managing risks and keeping people safe. Staff completed periodic training but records of this were not sufficient to confirm training was up-to-date and appropriate.

Some practices within the home did not promote people's privacy and dignity. The lack of maintenance and attention to environment was not demonstrative of respecting people's dignity. Staff and people using the service had good relationships and staff were caring in their approach to people. People and their relatives told us they felt staff were caring and supportive and communicated with them well. People were supported to have 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. People were involved in making everyday decisions linked to their care.

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 20 February 2020). The service remains rated Requires Improvement. 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 the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 20 February 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show

what they would do and by when to improve safe care and treatment and good governance of the service.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report covers our findings in relation to the Key Questions safe, and well-led which contain those requirements. We also reviewed the caring key question due to our findings during the inspection.

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 remained requires improvement. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed. We have identified continued breaches in relation to safe care and treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

The Langleys

Detailed findings

Background to this 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 team consisted of two inspectors.

Service and service type
The Langleys is a 'care home'. 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. The Langleys is a care home without nursing care. 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 there was a registered manager in post.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with two people who lived at The Langleys and three people's relatives to gather their experiences of the care provided. We spoke with the registered manager and two care assistants. Care assistants also completed catering duties. We observed the care and support provided to people to help us understand the experience of people who lived at the home.

We reviewed a range of records. This included three people's care records and multiple medication records. We viewed a variety of records relating to the management of the service including policies and procedures and health and safety checks.

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 the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Sufficient improvement had not been made at this inspection and the provider continued to be in breach of regulation 12.

● Assessment tools to determine risks to people's health and well-being, such as skin damage, falls or malnutrition were used. However, completed assessments were not always accurate to ensure any risks of ill health were effectively managed. For example, one person's risk assessment for skin integrity had not taken into account their on-going medical condition and the risks that posed to the person.
● One person was not eating well and was at risk of losing weight. Their care plan instructed staff to record what foods the person had consumed. Staff had not consistently followed this instruction.
● Environmental risks were not always managed safely. For example, wardrobes in people's bedroom were not secured to the wall. This meant the wardrobes could topple over and exposed people to the risk of causing them an injury.
● Risks associated with fire safety were not effectively managed. This included doors being wedged open which would not automatically close in the event of a fire.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of Regulation 12(1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The home had emergency arrangements with a nearby service if people needed to be evacuated.
● Following our visit, the provider confirmed they had taken action to address immediate environmental and fire safety risks including removing door wedges and securing wardrobes to the wall.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed safely consistently. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. Sufficient Improvement had not been made at this inspection and the provider continued to be in breach of regulation 12.

● Processes to support safe medicines practice needed to be improved to ensure people received their medicines as prescribed to treat their healthcare needs.
● Some people were prescribed a medicine to manage their pain on an 'as required' basis. Guidance was not available to inform staff when they should give these medicines in line with national guidance for 'as required' medicines. Staff had not recorded the reason when these medicines were given to ensure they were only given when necessary. This meant the provider could not assure themselves people's healthcare needs were being met safely and appropriately.
● One person was being administered an 'as required' medicine with a potential side effect of sedation for anxiety twice a day, every day. We were told this frequency had been advised by a healthcare professional but there was no written confirmation of these prescribing instructions. There was a risk the person was receiving sedation when this was not necessary.
● Two people were prescribed a pain relief patch to be applied directly to their skin which was to be rotated around the body to avoid unnecessary side effects. There were no records showing where the patches had been applied, or to confirm the old patch had been removed. There were no records of daily checks to ensure the patches remained in place. This placed the person at risk of discomfort.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a continued breach of Regulation 12(1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the provider told us they had taken the necessary action to review people's medicines with the relevant health professionals to ensure medicines were managed safely.

Staffing and recruitment
● Staffing arrangements were not clear or consistently managed to keep people safe. There had been no new staff recruited since the last inspection.
● Staff told us there were times when they felt they needed more staff. One staff member said, "Mornings are more busy, and we all say we could do with an extra member of staff in the morning.".
● Temporary agency staff were working at the home without sufficient checks. The registered manager had not obtained written confirmation or proof of checks such as agency staff's identity, training, and competence, to assure themselves these staff were safe and suitable to work with people.
● People did not raise concerns regarding staff but we saw care staff completed some ancillary duties such as cooking which meant at times there was only one care staff member available to support people. We observed a care staff member preparing food in the kitchen during the morning. During this time there were people in their rooms, people smoking alone in the garden and people in the lounge. The lack of care staff meant they could not effectively observe people to ensure any potential risks to their safety were maintained.
● Some people needed two staff to support them safely which meant there were no other care staff available to support other people during those times. It was not clear how risks would be managed in these circumstances, particularly if there was an emergency situation.
● Staff told us they completed training, but training records were not sufficiently clear to confirm all staff had completed the necessary training to support people's needs. This included mental health needs.

The provider failed to demonstrate there were sufficient numbers of suitably trained and competent staff to

ensure people were kept safe and their needs were met consistently. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People and relatives spoke positively about staff, one relative said, "Very pleased with them and the staff and have been extraordinary. They are approachable, you can say anything to them if you have concerns, they sit down and discuss it with you. I can't fault them."

Learning lessons when things go wrong

●The provider continued to miss opportunities to learn lessons. Despite the provider's attempts to make improvements, some aspects of the service remained unsafe. The provider remained unable to demonstrate compliance with the regulations.

● Staff understood their responsibility to report and record accidents or incidents. When we asked one staff member about unexplained bruising they responded, "I would ask the staff on the shift before me if they knew anything about it, ask the resident if they knew how they got the bruising. I would report it to the manager and do a body map."

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure systems and processes to protect people from the risk of abuse were sufficiently robust. This was a breach of regulation 12(1) 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 aspect of the regulation 12. However, further improvement was needed.

● Staff understood their responsibility to keep people safe. Safeguarding incidents we were informed about had been escalated so they could be investigated as appropriate.

● We gave one staff member a safeguarding scenario to check they understood the providers safeguarding procedure on how to respond appropriately. They told us, "I would definitely report it to the manager." demonstrating they knew it was their responsibility to do so.

● A centralised record of all safeguarding incidents was not maintained to enable the registered manager and provider to have an overview of these and identify any areas of learning.

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 the service was working within the principles of the MCA. Appropriate legal authorisations were in place to deprive a person of their liberty where needed to keep the person safe. Any conditions related to DoLS authorisations were being met.

● Mental capacity assessments had been completed. However, they did not always evidence how decisions were made. Care records reviewed did not show what steps were taken to promote the person's

involvement in the decision-making process. The registered manager told us staff would be attending training in mental health to help improve their understanding and recording of this.

Preventing and controlling infection

● We were not assured personal protective equipment was used effectively and safely. We observed occasions when staff were either not wearing a mask or were wearing their masks under their nose or chin in communal areas. The registered manager told us action would be taken to ensure masks were worn correctly by all staff and they would monitor this.

● We were not assured the provider was promoting safety consistently through the layout and hygiene practices of the premises. A bathroom used a sluice room (used for the disposal of human waste products and disinfection of associated items) had not been maintained in a clean condition to support good hygiene practice. The registered manager acknowledged our comments and following our visit confirmed they had added this to their quality check list to ensure it was effectively cleaned.

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

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

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

● We were assured that the provider was responding effectively to risks and signs of infection.

● 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

● There were no visiting restrictions in place. Relatives we spoke with told us they could visit at any time.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity

- People's privacy and dignity was not always promoted and maintained.
- One person's room had a toilet which had no screening such as a door or curtain, access to another person's ensuite toilet was blocked by the size and position of the bed. This meant the person either had to use a commode or alternative toilet.
- A bathroom on the first floor was not available for people to use as this was being used for an alternative purpose. This meant people had to use the bath and shower facilities downstairs resulting in them having to pass through the communal area. A relative told us, "I know it's an old properly the only drawback with the home is the shower facilities. The showers are downstairs, and you have to go through an area where everybody is sitting to go to the shower."
- Furniture and bedroom décor were not always maintained in a good order to ensure people lived in a comfortable and safe environment where their privacy was respected. For example, one room had a broken drawer handle that was sharp to touch which had the potential to cause harm. Other bedrooms had broken window blinds or ill hanging curtains which we identified had been like that for several weeks. This meant people could not close them or use them independently.

The provider failed to ensure people's privacy and dignity was respected and maintained. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff recognised the challenges of the environment and told us they wanted to provide an environment where people felt they mattered. One staff member explained, "I want to treat people how I would want my family to be treated and that is with respect and like a person, not just a number."
- People told us they were well treated and supported by staff who understood their individual needs. People shared good relationships with the staff who supported them. Staff understood people's preferences and lifestyle choices.
- Positive comments were received about the staff. These included "They look after [Name of person]. If they need anything, they do it for them" and "Staff have always done what I ask. I asked them to keep me updated with [Name of person's] care and they have been good in that sense."

Supporting people to express their views and be involved in making decisions about their care

- People told us they were involved in making day to day decisions about their care, but there was limited

evidence in care records that people had been involved in decisions about their ongoing care.
● We observed people made decisions about whether they sat in communal areas or their own rooms and decisions about what they ate and drank.
● Relatives said they were kept informed about the care of their family member. One told us, "If they have a concern they will ring and tell me, such as the doctor coming in. They keep me informed if there is an issue."

Inadequate

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. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At the last inspection the provider had failed to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Quality performance and risks had not been effectively managed.
- Since 2014 we have inspected The Langleys on six occasions. At each of those inspections the provider has failed to achieve an overall rating of good. Good care is the minimum that people should receive. This repeated failure demonstrates lessons have not been learned.
- The provider had failed to operate effective systems to review the quality and safety of the service. This meant concerns we found, had not been identified or addressed and opportunities to improve safety and learn lessons had been missed. This placed people at risk.
- The provider had failed to ensure compliance with the regulations. The provider has a history of not meeting the regulations and has not been able to demonstrate when improvements are made, they can be sustained. They have remained in breach of the regulations in relation to safety and good governance since January 2020.
- The provider had failed to maintain accurate and effective oversight of the service provided. This meant where improvements had been made, such as those to the décor of the home, these had not been sustained.
- The provider had failed to address risk management concerns identified by another agency in June 2022. During this inspection we found people continued to be at risk of potential harm. Arrangements in place to drive improvement, manage risks, and improve the care and support people received, were inadequate.
- Records continued to need improvement to demonstrate action taken in response to risks and concerns. This included environmental risk assessments as well as care risk assessments.
- Provider checks had not identified duty rotas had not been completed accurately in accordance with the colour coded key used to show how staff worked. This meant the actual hours staff worked across care and ancillary duties could not be accurately confirmed for the provider to assure themselves people's needs could be met safely and consistently.

The provider failed to have suitable arrangements in place to assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Arrangements were in place to help ensure managers and staff were clear about their roles.

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

● People were positive and felt their needs were met but the continued breaches of the regulations meant there were actions required to ensure people experienced good outcomes consistently.

● Some people had been accepted into the home outside of the 'older people' banding the provider had in place which meant there was a risk their needs may not be met appropriately.

● Overall, people and their relatives spoke positively of the care provided. There were some aspects of person-centred care they felt could be improved. This included the provision of more social activities and an increased understanding of mental health support needs.

● Staff felt the culture of the service was person centred and felt people's needs were met. They spoke positively about the registered manager. One staff member told us, "I think she is brilliant to be honest. [Registered manager] cares about her staff as well as the residents which is good."

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; Working in partnership with others

● The management team had some understanding of their responsibility around the duty of candour and worked in partnership with other agencies to support people's needs.

● There was no central record of complaints or concerns to support the provider in having an overview of these and ensure any lessons were learned.

● The provider was meeting the requirement to display their most recent CQC rating.

● The provider was actively involved in a local initiative to reduce demands on GP and hospital services.

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

● Arrangements were in place to help people and staff feel engaged and involved in the service.

● Satisfaction surveys were in the process of being submitted to people and/or their relatives at the time of our visit to obtain their views of the service.

● Staff attended meetings to keep up to date with what was happening at the home. Staff had opportunities to discuss any concerns with the registered manager and felt supported in their roles.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Arrangements in place to promote and respect people's privacy and dignity were not sufficient.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing arrangements did not demonstrate sufficient numbers of suitably qualified and competent staff were available to safely meet people's needs consistently.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks related to the health, safety and welfare of people were not sufficiently managed to maintain people's safety.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to monitor the quality and safety of the service were not effective.

The enforcement action we took:

Warning Notice