Liaise (South East) Limited

Langbury House

Inspection report

78 Langbury Lane
Ferring
Worthing
West Sussex
BN12 6QE

Tel: 01903709214
Website: www.progresshousing.com

Date of inspection visit:
06 October 2022
07 October 2022

Date of publication:
17 November 2022

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Langbury House is a residential care home providing personal care to four young people with learning disabilities and/or autism. The service can support up to five people. The service was a semi-detached bungalow with a garden, in a small coastal village. People had their own bedrooms and bathrooms. There were shared eating and living areas.
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found
Right Support:
Risks to people were not always assessed, monitored and managed safely. Systems in place did not always protect people from abuse and improper treatment. There were enough staff to meet people's needs. People's medicine support was being managed safely. The service was clean and hygienic. There were safe recruitment practices.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Right Care:
Staff did not always communicate or support people in dignified or respectful ways. Improvements were needed to make sure people were involved and included in a personalised way when being supported by staff. Professionals who worked with staff and relatives of people at the service gave us mixed feedback about the quality and safety of the support people received.

People and their relatives gave us mixed feedback about how involved and engaged they were with planning their support or developing the service, to help them achieve good outcomes.

Right Culture:
Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Internal quality assurance systems and processes to maintain and develop the safety and quality of care were not always operating effectively. Staff and relatives told us some aspects of the culture and leadership of the service required improvement to ensure people achieved good outcomes from their support. Staff, relatives and management told us on-going staffing turnover and vacancies at the service were impacting on staff morale and performance.

The provider was aware of and were committed to providing resources to make any necessary improvements as quickly as possible. Staff equality and diversity was respected and promoted at the service and within the provider's organisation.

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

Rating at last inspection
The last rating for this service was good (published 21 April 2021).

Why we inspected
We undertook this inspection to assess that the service is applying the principles of Right support, right care, right culture.

We received concerns in relation to staffing, uncaring support and people not being kept safe from abuse and improper treatment. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe, caring and well-led sections of this report. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to dignity and respect, risk management, abuse, and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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?

Requires Improvement

The service was not always well-led.
Details are in our well-led findings below.

Langbury House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was carried out by three inspectors and one assistant inspector.

Service and service type
Langbury House 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. Langbury House 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. Inspection activity started on 6 October September 2022 and ended on 17 October 2022. We visited the location's service on 6 and 7 October 2022.

What we did before the inspection
Before the inspection, we reviewed information we held about the service. We considered the information which had been shared with us since the last inspection by the provider, the local authority and other agencies and health and social care professionals. This information helps support our inspections.

During the inspection
We spoke with and observed the support of four people who used the service and their experience of the care provided. We spoke with seven members of staff, including the registered manager and the regional manager. We reviewed a range of records. This included four people's care and medication records. We looked at training data and quality assurance records and a variety of records relating to the management of the service, including policies and procedures. We received feedback from health and social care professionals. We spoke with or received email feedback from six relatives of people using the service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. 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, Learning lessons when things go wrong

- People with risks to their health and welfare related to their complex support needs, including aspiration and choking, eating and drinking, expressing emotional distress, and epilepsy were not always assessed, monitored and managed safely. These people's care plans' and risks assessments lacked detail or contained inconsistent information about how to manage these risks to their health and well-being safely. This included if they needed support to be able to make decisions about potential risks to their health. This increased the chances people could receive unsafe support.
- Staff were not always recording they were supporting people to have enough to eat and drink or clean people's eating and drinking equipment as per their risk assessment guidelines. This was not being monitored effectively by staff or management to check people were consistently being supported safely.
- Staff were supporting people who required specialist equipment to reduce aspiration risks when eating and drinking in ways which had not been assessed as being safe enough to do. Staff were supporting people in ways which were identified as being unsafe in their choking risk assessments.
- Some staff were not aware of important safety information in people's eating and drinking care plans and risk assessment. One person with swallowing difficulties had been assessed as requiring support to prepare food in certain ways, to reduce choking risks. We observed staff serving them food that had not been prepared as recommended in their choking care plans and risk assessment. This increased the chance the person might experience serious harm to their health.
- People's epilepsy and expressing emotional distress support plans contained incorrect and inconsistent details. This increased the chance staff would not know how to recognise and act quickly to reduce the risk of harm to people's health if they experienced epileptic seizures or periods of heightened emotional distress. Some staff we spoke with were not confident about how to support people with these needs. This placed people at potentially serious risk of harm to their health and increased the chance they may have experienced avoidable pain and discomfort or distress.
- Systems in place for staff and management to report, review and investigate safety incidents, and act to prevent them re-occurring were in operation. These required some improvement to ensure they were more effective. For example, ensuring staff reported incidents quickly enough and sharing learning to help prevent incidents re-occurring.

The provider had failed to assess, monitor and manage risks to people's' health and safety, provide safe care and treatment or ensure lessons were learnt. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- All of these risk management and lessons learnt concerns were fed back to the provider during the

inspection who acknowledged the issues and created an action plan detailing how they intended to make immediate risk management improvements.
● Environmental fire and health and safety risks were being manged safely. Any risks relating to these had been assessed and were being monitored regularly to help resolve any issues as quickly as possible.

Systems and processes to safeguard people from the risk of abuse,
● Systems and processes to keep people safe from abuse and improper treatment were not always operating effectively. There had been recent safeguarding incidents involving allegations of physical and psychological abuse against people at the service by two staff members, spanning an extended period.
● Staff had received safeguarding training and supervision, and there were safeguarding and whistleblowing policies outlining how staff could recognise, act and report abuse concerns. However, staff had not always acted to challenge or report suspected abuse concerns quickly when they had been allegedly occurring, as per the provider's polices. This had exposed people to risks of abuse and delayed the provider and other partnership agencies ability to be able to review and act on any abuse allegations to keep people safe.

The provider failed to ensure systems and processes protected people from abuse and improper treatment. This is a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● All staff members alleged to have participated in abuse towards people were currently suspended pending investigation by the provider, local authority and the Police. These investigations are still ongoing and no conclusions have been made. When made aware of the allegations, the provider acted quickly report and work with all appropriate external agencies to investigate the allegations.
● Following the allegations, the provider had implemented improved and more accessible ways for staff to report abuse and whistleblowing concerns internally and externally. Staff have been supported with a planned programme of refresher safeguarding and whistleblowing training, supervisions and learning workshops. Staff we spoke with during our inspection visits were aware of the updated safeguarding procedures and we saw there was information displayed throughout the service about the ways in which staff could report and abuse concerns.
● One person we spoke with told us they liked the staff. Relatives of people we spoke with told us they had been informed about the recent abuse allegations and offered assurances about steps being taken to investigate these by the provider. Relatives said they had not had any specific abuse concerns about staff at the service prior to being informed. During our visits we observed all people seemed relaxed and comfortable around staff.

Using medicines safely,
● Medicines were safely managed. Staff were recording administration of medicines accurately and consistently to help show people's medicines had been given as intended. Medicines were stored safely and hygienically. Medicines were given to people by staff who had been given training and supervision to help make sure they did this safely.
● Medicine stock control systems were operating effectively to allow staff to know how much medicine was being kept in the service and avoid having too much or too little stock of medicines being stored. Excess or unused medicines were disposed of safely via the local pharmacy. This helps reduce the chances of people not having enough medicines, medicines not being effective due to expiry or people's medicines being stolen or misused.

Staffing and recruitment
● Staffing rotas were managed safely. The service currently had several unfilled support and senior support

worker vacancies. The provider was employing regular long-term agency staff with suitable training, and staff and management were covering staffing vacancies to ensure enough staff were deployed on each shift while recruitment was on-going. Staffing rotas had been written to include at least one long-term permanent staff on each shift to help supervise agency and less experienced staff.

● Some relatives and staff told us they felt less experienced permanent and agency staff required more support to be able to meet people's needs safely and effectively, and this increased the pressure on other staff. The provider and registered manager were aware of this. Both permanent and regular agency staff had received inductions and had planned on-going regular training, supervisions and competency checks to help make sure they had the right skills and knowledge to meet people's needs safely.

● The provider had recently deployed senior staff from another service to help provide additional supervision for staff during each shift. The registered manager was block-booking the same agency staff when possible to ensure people were supported by agency staff who knew them and their needs well.

● The provider had systems in operation to help ensure safe recruitment practices. Pre-employment checks for potential new employees were carried out, to help prevent unsuitable staff from working in a care setting. This included Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Staff also had to provide references and employment histories.

● We reviewed a selection of permanent and agency staff recruitment files and saw that recruitment, induction and supervision processes had been followed as per the provider's systems and policies.

Preventing and controlling infection

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

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

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

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

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

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

Visiting in care homes.

● The provider was facilitating visits to people living at the home in accordance with current infection prevention and control guidance.

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.

Ensuring people are well treated and supported; respecting equality and diversity, Respecting and promoting people's privacy, dignity and independence, Supporting people to express their views and be involved in making decisions about their care

- People were not always supported in an inclusive or respectful way, offered choices or involved in their care. One relative told us they had concerns about agency staff employed by the provider, "Some are really good and interact with my son and other people…. (but) I have also seen agency staff sitting there doing absolutely nothing. If I see agency staff not interacting with him, it's just not good enough… It's a mixed bag really". Another relative said they felt sometimes the level of engagement and personalised support staff gave people was "very poor".
- We observed people were sometimes left alone for periods by their 1:1 support without the reasons for this being explained to them. When these people were alone and began to appear distressed, there was a delay in staff attending to them. We saw some staff not treating people in a dignified way. People in wheelchairs were moved sometimes without explanation about what was happening and why. One staff entered people's rooms while they were in them without knocking first.
- A healthcare professional shared concerns that they felt staff were not supporting people in a caring manner as they were not always communicating with people using their preferred non-verbal communication methods. Concerns had been raised by staff about another member of staff who had allegedly treated people in a disrespectful way by using their bathrooms and appliances for personal reasons whilst at work.

The provider failed to ensure people were always treated with dignity and respect. This is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Three other relatives we spoke with raised no concerns about staff not being caring or respectful towards their family member. One relative told us they visited every week and, in their experience, staff were always respectful and polite to people. We also saw examples of staff talking to people in a respectful manner and involving them in the support they were receiving.
- The registered manager told us they had regularly worked alongside staff and carried out observations of how they worked with people. They said, "I have never seen anyone behaving in a disrespectful manner towards people…staff do use age-appropriate language with the young people who live here, but I have never seen this being done in an unkind way".
- Staff, relatives and the registered manager told us staff supported people directly and indirectly via family

members and other advocates, if appropriate, to help them understand information about their support.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Internal quality processes to review and audit service performance and quality were not operating effectively. There were regular of comprehensive internal and external audits of all areas of care delivery at the service, but these had not always identified or prevented issues occurring or continuing at the service. This included audits not identifying issues with risk management, safeguarding and learning lessons and people's care records not being accurate or up to date, as identified during this inspection.
- A healthcare professional told us staff had not always ensured recommendations about their support needs were implemented consistently, increasing risks to the person's health.
- Leadership at the service and the provider's governance frameworks had not been effective in ensuring staff at all levels were aware or able to effectively fulfil their responsibilities to provide a good standard of care. At this inspection we found standards of care had deteriorated since the last inspection. Multiple breaches of regulations had occurred, placing people at avoidable risk of harm to their health and well-being and impacting negatively on their quality of life.
- Relatives, staff and management said the on-going staff turnover and vacancies were impacting the quality of care people received. The registered manager said, "I haven't had enough time or support to carry out my role because I have been covering night and day shifts". A staff member said, "I feel a bit rushed to carry out tasks I am not confident with…I feel the manager does not listen when I tell them this". A relative said, "The manager is rushed off their feet and can't fully operate their job during the day".

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was not always a positive, inclusive and empowering culture at the service. Staff and relatives raised concerns about the poor culture at the service and the negative impact on people caused by low morale, lack of cohesion about expected values and responsibilities and lack of open communication between staff at all levels.
- The registered manager said, "My biggest challenge is staffing and to make sure we are all of one mind". One staff said, "Some of the staff are not professional…I know there have been some issues and I've seen some staff be a bit stressed by this…there's just a bit of a bad vibe between some of the staff". We were told by another staff member that, "There have been some issues with some staff recently…Those staff were just really arrogant, they thought they could do whatever they wanted".
- A relative said, "In terms of senior management, I'd also feel absolutely fine raising issues. Not sure how

much me raising something will go very far, they can be a bit defensive and closing ranks going on". Another staff said, "I can speak to the manager, she listens, but doesn't always act on things".

There were failures to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, staff worked well with partnership agencies and service performance was evaluated and improved. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The registered manager and operations manager were aware of the need to make improvements to the culture, leadership and governance of Langbury House. During and after the inspection they sent us detailed action plans to help address and prevent these issues re-occurring.
● A person we spoke with told us they liked living at the service. Staff helped people to complete annual feedback surveys about how they were supported, and the service was run. Results from the latest survey in 2021 showed positive feedback from all people. Relatives told us they were able to share feedback about the care at Langbury House informally and via an annual survey.
● Staff equality, diversity and human rights was respected, promoted and upheld as per the provider's Equality and Diversity Policy. There was a diverse staff team employed at the service. Any necessary workplace adjustments had been made accordingly to ensure the maximum opportunity for individual staff and collective team development and progression.
● The provider had a vision and set of values that had been developed with people they supported across their organisation. The operations manager told us how they were actively looking to promote these values and how they linked with staff performance as part of the planned service and organisational development plans.

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 operations manager and registered manager understood their responsibilities regarding Duty of Candour. When the provider had been made aware of when things had gone wrong with people's support at the time, they had taken appropriate action to be open and apologise to all relevant people and agencies when things had gone wrong. Statutory notifications had been submitted to CQC in a timely manner, as required.
● Work staff did with health and social care professionals involved in people's care required improvement. It was not evident staff had always understood and implemented recommendations about support they should help to provide to people to ensure their health and well-being. Professionals agreed staff and management had shared information openly and transparently and were helpful in asking for advice and resolving issues if these were raised.

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 Failure to ensure people were always treated with dignity and respect is a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess, monitor and manage risks to people's' health and safety, provide safe care and treatment or ensure lessons were learnt. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure systems and processes protected people from abuse and improper treatment. This is a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

There were failures to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, staff worked well with partnership agencies and service performance was evaluated and improved. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.