Langford Park Ltd

Langford Park

Inspection report

Langford Road
Langford
Exeter
Devon
EX5 5AG

Tel: 01392690116
Website: www.langfordpark.co.uk

Date of inspection visit:
08 July 2021
15 July 2021

Date of publication:
07 September 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Langford Park is a 'care home' registered to provide accommodation, nursing and personal care support for up to 35 older people, people living with a dementia and younger people with a physical disability. At the time of this inspection there were 31 people living there.

People's experience of using this service and what we found
The new manager and provider were in the process of improving and developing quality assurance processes, however they were not yet fully established or embedded. This was evidenced by the issues we identified during the inspection related to medicines administration, risk management and staff knowledge and skills.

People were at risk because the systems for ensuring medicines were stored and administered safely were ineffective. The manager and provider expressed their commitment to promptly addressing the concerns raised.

Systems to monitor and manage risks did not always keep people safe. Staff had not maintained their knowledge and skills, which undermined their ability to provide safe care. There were no systems in place to monitor the effectiveness and safety of some equipment.

The service had not consistently submitted statutory notifications, which meant legal requirements had not been met.

The service was experiencing significant difficulties with staffing and recruitment. This was impacting on care provision and the staff team, although the provider was confident the service was safe. The provider had taken action to minimise risks by requesting support from the local authority, suspending new admissions and working with a wide range of staffing agencies. They had also increased the number of staff on shift and were proactive in addressing persistent staff absence and sickness.

The provider had endeavoured to keep families informed about issues related to COVID-19 using emails and videos posted on social media. However, relatives had mixed views about communication with the home related to their family member. None had been involved in developing or reviewing their family members care plan. Some told us they were kept well informed about the welfare of their family member and others felt this was lacking. The manager was introducing a resident of the day programme to better involve and engage people and their families.

There were effective systems in place to protect people from the risk of abuse. Concerns were escalated appropriately to the local authority, and investigations completed as required. Lessons learnt from accidents and incidents were used to prevent reoccurrences. Staff were recruited safely.

There were processes in place to keep people safe from the spread of COVID-19,

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The provider and management team led an open, transparent and person-centred service which helped people and staff feel valued and supported. They were committed to continuing to learn and improve, responding immediately to feedback given during the inspection and undertaking to address any concerns raised.

Staff were positive about the improvements introduced by the new manager and the way the service was being managed. The service improvement plan showed that progress was being made. One member of staff told us, "[Managers name] is communicating with everybody more broadly. It's less of a hierarchy than it was with the previous manager. We are now more of a team."

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 good (published 5 November 2020). There were no breaches of regulation. The service has now deteriorated to requires improvement.

Why we inspected
We received concerns in relation to staffing levels and the management of medicines and people's nursing care needs. As a result, we undertook a focused inspection to review the key questions of Safe 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.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 improvements. Please see the safe and well-led sections of this full 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 Langford Park 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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the management of risks; the management of medicines; the failure to submit statutory notifications 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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well led findings below.

Langford Park

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager who was not yet registered with the Care Quality Commission. This means that at the time of the inspection it was the provider who was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period of notice of the inspection to establish whether there were any additional risks related to COVID-19 we should be aware of prior to our visit.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to

complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and eight relatives about their experience of the care provided. We spoke with ten members of staff including the provider, manager, nursing and care staff, activities co-ordinator and administrator. We spoke with two visiting health care professionals.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at a variety of records relating to the management of the service, including policies and procedures, risk assessments and quality assurance records. We attended a local authority safeguarding meeting and heard feedback from a range of professionals who regularly visit 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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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.

Using medicines safely

- The systems for ensuring medicines were stored and administered safely were ineffective.
- Nurses did not effectively support and monitor a person whose medicine was administered via a syringe pump. This meant the person did not receive their medicines as prescribed.
- Staff did not consistently monitor the temperature of the fridge, or the room where medicines were stored, in line with relevant national guidelines.
- Some medicines had no opening or expiry date on them, so it was not possible to tell whether they were in date.
- Drugs requiring additional security were not being checked weekly to ensure they were safely managed and administered in line with relevant national guidelines.
- Staff were unsure where creams should be applied, and there were no body maps in place to guide them.

This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008.

- We discussed these concerns with the manager and provider. They welcomed the feedback and expressed their commitment to addressing these issues promptly.
- Staff told us the electronic medication system was complicated to use, and it was easy to make errors. They were double checking to ensure medicines were administered safely. The provider was seeking support from the manufacturer to address this issue.
- Staff received the necessary training to administer medicines safely, and their competency was regularly checked.
- There were auditing arrangements in place regarding medicines. Processes were in place for taking decisive action in the event of medicines errors and minimising the risk of recurrence.

.

Assessing risk, safety monitoring and management

- The systems to monitor and manage risks were not always effective.
- Staff had not maintained their knowledge and skills, which impacted on the management of risks and the safety of the support provided. This was evident in relation to clinical knowledge and practice, moving and handling skills and supporting people living with dementia. A relative told us, "Some of the carers have no empathy. There needs to be more training of the carers for dementia as the majority of the people in the home have dementia."
- People had received skin tears due to poor moving and handling.
- People were at risk of harm because equipment was not checked to ensure its safety and effectiveness. For

example, pressure area care mattresses were not checked to ensure they were safe and at the right setting for the person. The safety of bedrails was not monitored.

This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008.

●The manager was aware of the need to improve staff knowledge and skills and was doing so through training and staff supervision.
●Three nurses had recently left the nursing team and there had been a delay in sourcing clinical training for new staff due to the COVID-19 pandemic. This had now been arranged and was in progress. In addition, shadowing opportunities were being set up for the nursing team in alternative health care settings to put their knowledge into practice.
●The clinical staff we spoke to on the day of the inspection were knowledgeable and skilled, and recognised their additional training needs. They were proactive in contacting external specialists for support and guidance if required.
●There was a focus on minimising risks related to social isolation and poor mental health. The manager was introducing a system to monitor peoples mental wellbeing on a monthly basis. People were encouraged to engage in a range of activities according to their individual needs. On the day of the inspection a 'beach party' was in progress, with 'mocktails' and an ice cream van.
●Relatives had had limited contact with their family members during the lockdown. Several told us their family member was living with advanced dementia and had not been able to tell them about the care they received. They therefore assumed they were well supported based on their physical appearance and demeanour. Comments included, "We are pleased about the way they are looking after [our family member]" and, "I think they are keeping her safe. When she was at home, she was very anxious… They handle this well and they have sorted her out. It is important to be assured there is help on hand."

Staffing and recruitment
●On several occasions throughout the visit, there was an absence of visible staff in communal areas. One person said, "There are never enough staff, and they are not fairly distributed. If somebody needs the toilet and they need two staff, they have to wait." A relative told us on one occasion their family member had not been supported with personal care, or to get out of bed during the day adding, "This was unusual, most of the time it's fine."
●Staff advised they were short staffed on occasions but were confident it was a safe service. They were doing the best they could to ensure people had their basic care needs met, going without breaks and picking up extra shifts.
●The provider and manager confirmed they had experienced difficulties with staffing, largely due to staff leaving, recruitment difficulties, last minute staff sickness and staff needing to self-isolate. In addition, agencies were not always able to provide staff. They were working to address this and provide a safe service.
●Staff were recruited safely, and appropriate checks were carried out to protect people from the employment of unsuitable staff

Systems and processes to safeguard people from the risk of abuse
● People were protected from potential abuse and avoidable harm by staff who had safeguarding training and knew about the different types of abuse.
● Staff told us they felt confident to report any concerns and knew that action would be taken.
● The provider now had effective safeguarding systems in place. Following the last inspection, it transpired safeguarding concerns, accidents and incidents had not been reported by the previous manager. Staff meeting minutes showed the importance of raising concerns had subsequently been reinforced with the staff team. Records showed that concerns were now being escalated appropriately to the local authority,

and investigations completed as required.

Preventing and controlling infection
●We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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

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

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

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

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

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

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

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

Learning lessons when things go wrong
●Lessons were learnt when things went wrong. For example, following some inappropriate admissions to the service a new admissions policy had been devised. This meant any potential new admissions were screened by four members of the management and nursing teams to check the person's needs could be met at the service.
●Records showed the manager was proactive in ensuring lessons were learnt from significant incidents, holding debriefing sessions with the staff team.
●There were processes for documenting and reviewing accidents and incidents, and safeguarding concerns. An analysis of this information was completed to identify any patterns and trends.

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

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

●At our previous inspection in September 2020 we found the service had not consistently met its regulatory requirements to provide us with statutory notifications as required. This was still the case at this inspection.

The failure to submit statutory notifications is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

●At our last two inspections in September 2019 and June 2020 we found systems to monitor the quality of the service were not fully established or embedded. This was still the case.

●A new manager had come into post in April 2021 and was in the process of registering with the CQC. They and the provider had identified failings in the management of the service and quality assurance processes. Action was being taken to address these failings, however the issues we found related to medicines administration, risk management and staff knowledge and skills showed they were not yet fully effective or embedded.

We found no evidence that people had been harmed however, systems were not sufficiently robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. The was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider was very involved at the service and described the challenges in staffing and recruitment. They told us, "It's been really hard in the industry. Being able to retain nurses is difficult and we don't have the European workers coming through. I believe the home is safe, although we've been cut to the bone at times."

●The provider had developed an operational risk management process, which had been used in the current staffing crisis to review risks and plan actions required to minimise them. They had requested support from the local authority, suspended new admissions, and were working with a wider range of different staffing agencies. In addition, they had increased the number of staff on shift and were proactive in addressing persistent staff absence and sickness.

●The new manager and provider were working to improve and develop quality assurance processes.

Regular audits looked at all aspects of service provision, including medication administration, call bell response times, activities, mealtimes, documentation, staff support and training and environmental risks. The service improvement plan showed that progress was being made.

●The provider had commissioned an independent consultant to carry out mock CQC inspections. The manager told us, "It will be helpful to have somebody independent and impartial who can pick up anything I've missed."

● The operational structure provided clarity around responsibilities and accountability within the home. It was being reviewed and adapted to meet the changing needs of the home and the people living there.

●The manager aimed to be visible at the service and had worked alongside staff at weekends and on night shifts. This enabled her to get to know the people living at Langford Park and to monitor staff practice.

●The manager had introduced a whole staff team daily handover to ensure information about risks was shared and understood. Topics included staffing issues; care concerns; maintenance issues; housekeeping; kitchen and activities.

●Staff were positive about the new manager. Comments included, "[Managers name] is very easy to talk to and her door is always open. She's responsive and listens to what you say ", and "[Managers name] is communicating with everybody more broadly. It's less of a hierarchy than it was with the previous manager. We are now more of a team."

●Relatives were aware a new manager was in place, although had not yet met her. One relative told us, "I don't think that the manager is very accessible. For one thing she has a 'Do Not Disturb' notice on her door and I think this is very off-putting."

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

●Relatives we spoke to had mixed views about communication with the home in relation to their family member. None had been involved in developing or reviewing care plans. Many found out what was happening at the home through social media. Comments included, "I had a questionnaire to fill in last year. We do get emails, but I don't think we are kept very well informed" and "The communication is quite good. They do phone me straight away if anything happens – even if it is insignificant."

●The manager was planning a 'Resident of the Day' programme, to better engage people and their families. This would include inviting people and their families to visit monthly to discuss the support provided and review the care plan.

●Surveys had been used to obtain the views of people and staff about the way the service had managed during the COVID-19 pandemic. Questions included the impact of masks on communication, and the provision of information.

●Residents meetings provided an opportunity for people to express their views and raise any concerns. Issues discussed at the last meeting included call bells, personal care and the noise level at night.

●The provider had endeavoured to keep families updated on issues such as visiting arrangements, vaccinations and testing using emails and videos posted on social media.

●Regular staff meetings were held for all roles at the service. This was an opportunity for information and updates to be provided, and for staff to express their views.

●The provider and manager had dedicated 'open door' times for staff to come and speak with them. Anonymised minutes showed their concerns and suggestions had been listened to and action taken.

● The provider and manager ensured staff who had gone 'above and beyond' during the pandemic were recognised and rewarded for their contributions. The providers statement said, "It is in times of crisis that heroes are born and during the last 15 months, every single one of you have shown us what incredible people you are. We are proud to say that you all work for Vision Care. I am proud and inspired by the way you have all risen to this challenge - with flexibility, resilience, courage – and a caring heart."

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

●The provider and management team promoted a transparent and open culture. The service had a clear value base which was promoted through staff induction and training.

●The provider and manager were open and honest throughout the inspection. They welcomed the feedback given and were committed to addressing the concerns raised.

●Staff spoke positively about the culture of the home. One member of staff told us, "I like to work somewhere that is all about the residents. Here everything is about them and their needs. They try and make it a nice place for the staff to work. "

●A relative told us, "My [family member] rates the home very highly. She is happy and she looks clean and tidy. She is eating well, and they often have cake which she likes. They go out of their way to provide something special for the residents."

Continuous learning and improving care.

●Staff were supported to continue with their professional development.

●A leadership and management course was in progress for all nurses and team leaders, which staff told us was "really good."

●A mentorship programme was in place, endorsed by Skills for Care. This was to provide training to staff in how to induct and support newly recruited employees. A newly inducted member of staff told us the induction programme had been very thorough saying. "It's the best induction I've been on."

●The new manager came from a clinical background and was conducting clinical supervisions for the nurse team and assessing their competence.

Working in partnership with others

●The provider was committed to working constructively with the local authority to address the challenges they were facing related to staffing and recruitment.

●Visiting health professionals were positive about the way staff worked with them to support people. They told us, "They are very helpful. They listen and take on board what you say and ask for written notes. Communication is good. We have no concerns about Langford Park."

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service had not consistently met its regulatory requirements to submit statutory notifications as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The systems for ensuring medicines were stored and administered safely were ineffective. 12(2)(g) The systems to monitor and manage risks were not always effective.12(2)(a)(b)(c)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor the quality of the service were not fully established or embedded. 17(2)(a)(b)