Cumbria County Council

Langrigg House

Inspection report

Langrigg Road
Carlisle
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23 October 2015

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 21, 22, 23 October 2015. We last inspected Langrigg House in November 2013. At that inspection we found the service was meeting the five regulations that we assessed.

Langrigg House is a residential home located in the West of Carlisle and is close to all the local amenities and services. The home has five units, On the ground floor there is a unit that provides care and support for people living with dementia and a respite unit. On the first floor there are three units providing care and support to frail and elderly people, these three units are not physically separated but each have there own seating and food preparation areas.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

We found at this inspection that there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not sufficient numbers of support staff at night time to meet the assessed needs of people living in the home and in emergency situations. Furthermore staff had not received sufficient appropriate training to support people who lived with dementia.

You can see what action we told the provider to take at the back of the full version of the report.

We made the following recommendations:

We recommended that the service review the way they stored medicines.

We recommended that the service review its schedule of works with a view to completing renovations in a timely manner.

We recommended that the provider review their best interest decision making process to ensure it followed guidanceoutlined in the Mental Capacity Act 2005.

We recommended that the provider responded to issues highlighted by their registered manager and their quality assurance system in a timely manner.

People who used the service told us that they felt safe. Staff knew how to identify and report abuse.

The service had safe systems for the recruitment of staff to make sure the staff taken on were suited to working there. However the registered manager and the staff told us that recruitment took some time.

People's nutritional needs were identified through assessment. Kitchen staff and care staff knew how to meet people's nutritional needs. The manager had responded to a concern raised about the menus and was improving them.

People told us that staff were caring and spoke to them in a respectful way.

People knew how they could complain about the service. People we spoke with were confident that action would be taken in response to any concerns they raised.

The registered manager in the home supported staff. She had identified issues that we highlighted and alerted the provider.

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.

There were not sufficient numbers of care staff at all times to meet the assessed needs of people living in the home and in emergency situations.

The way medicines were managed and stored required a review.

Staff were capable of identifying and reporting abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Training was not appropriate to the identified needs of people who used the service.

The process of making best interests decisions in reference to do not attempt cardio pulmonary resuscitation (DNACPR) required review.

The building required significant refurbishment and although this was underway we asked the provider to review its schedule of works.

Is the service caring?

Good

The service was caring.

People told us that they were being well cared for and we saw that the staff were respectful and friendly in their approaches.

Staff demonstrated good knowledge about the people they were supporting, for example information on their backgrounds and preferred activities.

We saw that staff maintained people's personal dignity when assisting them. Staff also offered explanation and reassurance about what they were doing.

Is the service responsive?

Good

The service was responsive.

There was a system in place to receive and handle complaints or concerns raised.

People were able to access the local community.

Care plans were reflective of people's needs

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager had identified areas for improvement in the home and informed the provider. However the provider had not responded to her concerns in a timely manner.

The manager had clear expectations of the standard of care provided.

People who lived in the home and their visitors were able to give their views of the service.

Langrigg House

Detailed findings

Background to this inspection

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

This inspection took place on 21, 22, 23 October 2015 and was unannounced. The inspection was carried out by two adult social care inspectors.

During the inspection we spoke with 10 people who lived in the home, 14 care staff, a member of kitchen staff, and the registered manager. We also spoke with two visiting relatives and a visiting health and social care professionals. We observed care and support and staff interactions in communal areas and at breakfast and lunch time.

As part of the inspection we looked at 10 care records and care plans relating to the use and storage of medicines. We looked at people's individual care records and risk assessments to help us see how their care was being planned with them and delivered by the staff. We also looked at the staff rotas for the previous two months, staff training and supervision and recruitment records. We also looked at records relating to the maintenance and the management of the service and regarding how quality was being monitored within the home.

Before our inspection we reviewed the information we held about the service. We looked at the information we held about notifications sent to us about accidents and incidents affecting the service and the people living there. We looked at the information we held on safeguarding referrals, concerns raised with us and applications the manager had made under Deprivation of Liberty Safeguards (DoLS).

Requires Improvement

Is the service safe?

Our findings

We spoke with who people who lived at Langrigg House they told us that they felt safe in the home and felt the staff worked, "Very Hard." One person said, "When I press the buzzer I don't wait for too long."

We spoke with a visiting relative and they told us, "I'm pleased my [relative] is here, it's a good home."

We spoke with staff who told us,"We enjoy coming in and doing a good job, making it nice for the residents, but it can be exhausting." And, "Recruitment happens, but it seems slow." And, "We lost the laundry person, they have not been replaced, we have enough to do with care without laundry and cleaning duties."

We had received information that there were not sufficient staff at night within the service. For this reason we visited the home both at night and during the day.

When we inspected at night we found that there were two care staff on duty. They were supporting 36 people across two floors. Of those 36 people over half required at least one person to support them to get up out of bed or go to the toilet. Furthermore some people had plans in place to be turned regularly at night to help protect their skin and prevent them from developing pressure ulcers, also known as bed sores. This meant that in order to meet people's needs staff were leaving units unattended for long periods of time. This included the unit that supported people who lived with dementia. We saw that there were open stairwells in this unit which meant there was a risk of people accessing the stairs and falling up, or down, them. As a consequence of these findings we asked that staffing at night be increased with immediate effect. The provider redeployed staff from other homes within its organisation staright away.

We looked at staffing during the day and saw that staff were meeting people's needs in a timely manner. However we did note that both the day staff and the night staff had been given cleaning duties that could have been carried out by non care staff such as a cleaner.

We looked at how the provider calculated how many staff were required to support people at Langrigg House. We could find no evidence that staffing levels had been set based on people's needs. They were in fact based on historical figures, for example we were told the service had always had two staff working at night. The provider was aware that the needs of the elderly population were changing with more people being supported for longer within their own home. This meant that people who used the service were likely to have an increased amount of needs requiring an increased amount of support. The provider had made no provision for this.

We spoke with the registered manager. They told us that they were aware of the problem and provided evidence that they had recruited additional staff and were awaiting checks to be carried out on new employees. They explained the recruitment procedure to us. We noted that they had to submit a business case for each vacancy outlining why they required staff. This was sent to the providers human resource department to be signed of by senior staff within the organisation. The registered manager told us this process often took some time and she had not always been successful with her business cases. For example

she had requested a general assistant to work in the laundry and perform cleaning duties in order to reduce the burden on care staff. However this had been refused.

During our inspection the provider and registered manager agreed that staffing in the home, particularly at night, would be increased in order to ensure the safety of the people who used the service. The registered manager subsequently updated us to their progress in this area and assured us that there would be at least three staff on during the night at all times.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not sufficient numbers of support staff at all times to meet the assessed needs of people living in the home and in emergency situations.

We looked at the way medicines were managed and handled in the home. We saw that the staff administering the medicines had received appropriate training to do so and that they gave people the time and the appropriate support needed to take their medicines. We looked at the the storage of medication. We saw that the medicines, including controlled medications, were stored in a room that was accessed by staff and people who used the service. This meant that medicines could potentially be accessed by people not authorised to do so.

We recommended that the service review the way they stored medicines.

We spoke with staff who told us that they had received training on recognising possible abuse and knew what action to take if they felt someone needed to be safeguarded from abuse or possible abuse. They told us they would report it to the supervisors or registered manager to look into and pass on to social services. Staff were also aware of the procedures for reporting bad practice or 'whistle blowing' and told us they would report poor practice if they saw it. Training records indicated that all care staff had received this training.

We looked at staff recruitment records of the newest staff to see that checks had been done to help ensure staff working in the home were only employed if they were suitable to work in a care environment. We saw required Disclosure and Barring Service [DBS] checks had been done and references obtained.

Requires Improvement

Is the service effective?

Our findings

We spoke with people who used the service and asked if them if they thought the staff were knowledgeable about the support they required. People told us they were satisfied with the support they received, one person said, "The staff are good staff."

We looked at the staff training records which showed what training had been done and what was required. We saw that staff had done induction training when they started working at the home and they received regular updates on important aspects of their work such as moving and handling. We saw that not all the training was up to date. We spoke with the registered manager and she explained that there were currently some job vacancies at the home which meant that staff had been unavailable to complete training. However she showed us a training plan that demonstrated that staff would be brought up to date with their training in the near future.

We looked at the types of training available. We noted that there was no in depth training available for the care of people who lived with dementia. We spoke with the staff and the manager who confirmed this. In addition we noted that some care plans stated that staff were to utilise their dementia training when faced with behaviour that challenged the service.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff had not received sufficient training to appropriately support people particularly those who lived with dementia.

We noted that the home required extensive refurbishment. This included the décor that was old and damaged in places and the bathrooms and toilets that contained surfaces that were difficult to keep clean. The windows and window sills in the home also required replacement.

We recommended that the service review its schedule of works with a view to completing renovations in a timely manner.

We looked at care plans to see how decisions had been made and recorded around 'do not attempt cardio pulmonary resuscitation' (DNACPR). We saw that GPs had made clinical decisions as to whether or not attempts at resuscitation might be successful. No one living there had an advance directive to indicate particular treatment preferences in the event of not being able to make a decision.

We noted that some forms stated that they had been completed in the best interests of people who used the service. Guidance on how to act in people's 'best interests' is outlined in the Mental Capacity Act 2005. The act states people's levels of capacity to make important medical decisions must be measured and documented. We found no evidence to suggest that people's levels capacity had been formally noted in the written records

We recommended that the provider review their best interest decision making process to ensure it followed

guidanceoutlined in the Mental Capacity Act 2005

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the MCA. The MCA and DoLS provide legal safeguards for people who may be unable to make decisions about their care. The registered manager knew when a Deprivation of Liberty Safeguard was required to protect an individual's rights. We saw that the registered manager had raised potential restrictions with the managing authority to make sure they were acting in line with the legislation and supporting people's rights.

We saw that people had nutritional assessments in place and that their weights were being monitored. We saw that advice had been sought from the speech and language therapist (SALT) on choking risks for individuals. There was also information on specific dietary needs such as diabetic diets and soft and pureed meals as well. the information gathered was used to formulate care plans tailored to meet people's identified needs. This meant that people were receiving support with maintaining a healthy diet and that their hydration needs were being met.

People's health and support needs had been assessed before admission and we saw that people had access to appropriate health care professionals to meet their individual health care needs. We saw records in the care plans of the involvement of the community mental health team, district nurses and specialist nurses as well as opticians, chiropodists and dental services.

Good

Is the service caring?

Our findings

People we spoke with told us they felt cared for by the staff in the home. One person commented, "The carers are all lovely."

Relatives we spoke with told us, "We are very happy."

We observed staff caring for people in a relaxed, warm and friendly manner. Staff took time to speak with people who used the service. On occasion we saw that non care staff who worked in the home such as kitchen staff took the time to chat with people.

We looked at how the service supported people to express their views and be actively involved in making decisions about their care and support. We saw that many people who lived in the home were capable of making their own decisions about the way they chose to live. For example people were able to rise or go to bed as they pleased and people's bedrooms were decorated to their own tastes. We observed one person who chose to stay up late and watch television in the communal lounge. The staff told us that they believed it was beneficial to this person and supported them accordingly.

We saw that people were able to access advocacy services if they required support to make their feelings known. The registered manager was aware of the need for these services and ensured people were informed of their rights relating to this.

People's privacy and dignity was upheld. We observed that staff took care to ensure people's doors were closed when they were receiving personal care. Staff we spoke with knew that maintaining people's privacy and dignity was important. When we looked at people's care plans we noted there were references to maintaining people's privacy and dignity in them.

There were policies in place relating to privacy and dignity as well as training for the staff in this area. There were also policies in place that ensured staff addressed the needs of a diverse range of people in an equitable way. Staff received training on equality. This meant that the service ensured that people were not discriminated against.

The staff we spoke with understood the importance of providing good care at the end of a person's life and told us how they worked with the district nurses and GP to provide this support if needed.

There were organisational policies in place to help staff deal with the personal aspects of supporting people at the end of their lives and their families. There was a procedure to allow staff to discuss this or 'debrief' if they had found this aspect of care difficult.

Good

Is the service responsive?

Our findings

We asked people about raising concerns in the home. Overall people were aware of how to do this. One person told us, "I had a complaint once, I told the supervisor and it got sorted straight away."

We saw that there was a complaints policy in place that outlined how to make a complaint about the service. The policy contained guidance as to how long a complaint should take to be investigated and what to do if complaints were unresolved. It also contained information as to how to access support when making a complaint for example using advocacy services.

We spoke with the registered manager. She told us she always attempted to resolve complaints informally if possible. She showed us her complaints file which contained information about complaints about the service and how they had been resolved. We saw that the registered manager always apologised on behalf of her team, the service and the provider when complaints against them were upheld.

We looked at the written records of care for people who used the service. We saw evidence that indicated the service had carried out assessments to establish people's needs. For example some assessments indicated that people needed support to mobilise. Plans were in place to ensure that people were supported to mobilise correctly and appropriate equipment had been purchased.

We looked at 10 written records of care. The service had gathered some information about people in order to try and ensure that care plans were person centred. For example information about people's likes and dislikes were used to formulate care plans relating to people's daily routine and their nutrition.

Reviews of care plans were carried out regularly and involved the person receiving support. Where necessary their relatives and other health and social care professionals were invited to these reviews.

We saw that people had a 'hospital passport', this had information about the person, their health and care needs, medication and what they needed in order to support them. This was to help make sure that should a person need to transfer to another care setting quickly all the relevant information would be available.

During our inspection we observed people taking part in activities that had been organised by the staff in the home. We saw that some people had electric scooters that enabled them to continue to access the local community. In addition we observed people being taken out by their relatives. However we noted that there was no dedicated activity co-ordinator in the home and some people told us that they could be bored.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with told us that they had met the manager and often saw her, "Out and about."

The home had a registered manager in place as required by their registration with the Care Quality Commission (CQC). We saw during our inspection that the supervisors and the registered manager were accessible and spent time with the people who lived in the home and engaged in a positive and open way with them. All the staff we spoke with told us that they had regular staff meetings, formal supervision and felt they were supported in their work.

We saw that the registered manager deliberately chose to work shifts alongside her staff. She told us, "I like to know what is going on in my home."

In addition to the managers direct observations there were systems to assess the quality of the service provided in the home. Audits and checks were carried out regularly and included checks on medication, paperwork and health and safety.

We saw that customer satisfaction surveys had been carried out and information gathered had been used to improve the service. For example the registered manager had noted a general dissatisfaction with the food and had organised for the menu to be reviewed.

The registered manager formally spoke with four people a month to ensure they were satisfied with the service and also held residents meetings. The operations manager visited the home on a monthly basis to do service checks and monitor quality.

The registered manager used all the information she gathered to inform her where she felt the service was performing well and what areas required improvement. She communicated this information to the provider. She told us, "I'm fairly happy, I don't go home at night and worry about the care." And went on to say, "The home needs refurbished, an activities coordinator, full staffing and more auxiliary staff."

We recommend that the provider respond to issues highlighted by their registered manager and their quality assurance system in a timely manner.

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 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: This was because there were not sufficient numbers of support staff at night time to meet the assessed needs of people living in the home and in emergency situations. Furthermore staff had not received sufficient training to appropriately support people who lived with dementia.