Jaffray Care Society

Langdale and Keswick (Parkfields)

Inspection report

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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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

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.

About the service
Langdale and Keswick (Parkfields) is residential care home made of two bungalows providing personal care to seven people at the time of the inspection. The service can support up to eight people with learning disabilities and/or autism.

People's experience of using this service and what we found

Right Support
Lessons were not always learned when things went wrong as incidents were not always thoroughly reviewed to ensure practice could be improved. Medicines were generally managed safely, and feedback was acted upon when areas for improvements were identified during the inspection. People were protected from the risk of cross infection, where possible. Staff enabled people to access specialist health and social care support in the community, although some improvements were needed to ensure advice was promptly followed.

Right Care
Staff understood how to protect people from poor care and abuse, however incidents were not always reported. The service did not always have enough appropriately skilled staff to meet people's needs and ensure they led a fulfilling life. However, staff were recruited safely. People who had individual ways of communicating, using body language, sounds, Makaton (a form of sign language) or objects of reference could not always interact comfortably with staff because staff did not always have the necessary skills to understand them. People received kind and compassionate care. Staff protected and respected people's privacy and dignity. People were supported to have food and drinks in line with their choices and needs.

Right culture
People did not always receive good quality care, support and treatment because staff did not always feel they had sufficient training to effectively support people. People were not always supported by staff who understood best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. There had been a recent increased staff turnover, which meant people did not always receive consistent care from staff who knew them well. Despite this, relatives were positive about the support their loved ones received. The provider and registered manager were responsive to feedback and open to discussions about our inspection findings.

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 4 April 2019).

Why we inspected
We undertook this inspection to assess that the service is applying the principles of 'Right support, right care, right culture'. This was because we had received concerns about how people were being supported, so we wanted to check people's care.

Enforcement and Recommendations
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 breaches in relation to safeguarding, training of staff and quality assurance systems 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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Langdale and Keswick (Parkfields)

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
One inspector visited the home. A member of the CQC medicines team reviewed medicine records off site. An assistant inspector, along with the inspector, made telephone calls to speak with relatives, staff and other professionals that worked with the service.

Service and service type
Langdale and Keswick (Parkfields) 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. Langdale and Keswick (Parkfields) is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced

What we did before inspection
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 asked the local authority and Healthwatch for feedback about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We made observations in communal areas of how staff interacted with people who used the service. We spoke with five relatives about their experience of the care provided.

We spoke with seven members of staff including care workers and senior care workers. We also spoke with the registered manager, a manager from another service who was working at the home temporarily, the maintenance manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included two people's care records and seven people's medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke in detail with four professionals who supported some people who used the service and had some email feedback from multiple other professionals.

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.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding referrals had not always been made to the local safeguarding authority.
- Staff were aware of different types of abuse, signs to look out for and their responsibilities to report it. Incidents which needed to be reported to safeguarding were being documented by staff, but these had not been reported. The registered manager had also failed to ensure these were reported.
- Following our feedback, some referrals were made to the local safeguarding authority, but they had failed to refer all incidents. We prompted them to do this following the inspection.

This constituted 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.

Learning lessons when things go wrong; Assessing risk, safety monitoring and management

- Lessons were not always learned when things went wrong.
- When people had experienced distress or become upset, which had resulted in altercations between people or with staff, these were not always being thoroughly recorded and reviewed to ensure lessons could be learned.
- Staff and the management team were not reflecting on incidents to learn what worked to support the person, in order to then update their care plans and risk assessments and to improve care and support to people. One professional told us, "It's not clear how the manager is reviewing these incidents."
- Risk assessments were in place for people's health and well-being. However, as incidents were not being learned from, we could not be sure these remained consistently up to date and detailed enough.
- Following our feedback, the nominated individual and registered manager agreed to consider a system to make improvements and to review people's care plans.

Staffing and recruitment

- There were enough staff, so people did not have to wait for support. However, the staffing levels did not enable people to regularly engage in meaningful activities they liked, such as accessing the community.
- One staff member said, "Staffing levels are impacting people's ability to go out. We used to go out at least once a week. We'd go for a lunch. We don't have enough staff to do that." Another staff member said, "[Person's name] likes going out but there are not enough staff to cover. It is massively impacting on how people behave."
- We asked the provider about this and they explained they felt the COVID-19 pandemic had affected the service. They also explained they had asked for additional funding as some people may need extra support

in the community, however they had not been given this. Following our inspection, the provider told us they would recruit extra staff to support people with meaningful activities.
● Staff were recruited safely. Checks were made on their suitability to work with people who used the service, such as on employment history, references and criminal records checks (known as Disclosure and Barring Service (DBS) checks).

Using medicines safely
● Medicines were generally managed safely, however improvements were needed to guidance available for staff about 'when required' medicines.
● Guidance for 'when required', also known as PRN medicine, was not always up to date and sufficiently detailed. Despite this, we did not find anyone had received too much of their specific medicine used to help calm people down. One relative said, "Staff only [give the PRN medicine] in circumstances my relative is very anxious, they normally tell me when it's been given, they record it when it's given." Following our feedback, the provider agreed to review and update these.
● One medicine had expired, and this had not been identified through checks. This had not been given to the person after expiry, so no harm had occurred.
● Stock levels matched records so two staff would sign to say medicine had been administered, to reduce the risk of errors.

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 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.
● People were supported to maintain contact with loved ones, which included visits from relatives into the home or outside of the home and contact via phone calls.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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 the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People were not always supported by staff who had received relevant and good quality training in evidence-based practice.
- Staff did not always have the training and confidence to know how to support people effectively, particularly during periods of distress. There had been staff turnover, so some long-term staff had left. One relative told us, "It has been recent there have been concerns. Long term staff are leaving."
- One staff member said, "I have completed all my mandatory training. The basic training is good, but I think it could be improved, I have not received training for distressed behaviours."
- Professionals who worked with the service also fed back about staff training. One professional said, "The recording suggests staff are not well trained." Another professional said, "Staff do not seem skilled [in relation to supporting people with distressed behaviours]."
- Staff told us some incidents meant staff would have to physically intervene to protect others or staff. However, records showed 16 out of 25 staff had not had training to do this safely, and those that had the training had not had it recently. This training had been arranged prior to our inspection and was delivered following our site visit. However, people and staff had still been left at risk prior to this, if physical interventions are not carried out in a safe manner.
- Staff were not trained to use different communication techniques other than verbal communication. Some of the people using the service were unable to communicate verbally or had reduced ability to communicate verbally. Other methods such a picture cards or sign language were not being used by staff as they had not been trained.
- For example, one staff member said, "I have not had any training about communication." Another staff member said, "I have not had any training in communication, I think it is needed. We don't have any aids or devices; I don't know Makaton or any signing."
- When we asked the registered manager about different methods of communication they said, "That's something I want to implement." Therefore, these were not in use. The registered manager also explained they had made referrals to the Speech and Language Team for support following our feedback.
- Due to staff turnover, some staff had left which had caused a shortage of staff qualified to be able to drive people. One staff member said, "Normally people go out often, but now we don't have many drivers." This meant people had missed opportunities to access the community as there was a lack of trained staff.

Staff were not always suitably trained and competent in some aspects of people's care. This constituted a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This constituted a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this, some relatives felt people were well supported. One relative said, "Staff know how to work with my relative. They have had support off [other professionals] with what to do."

Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were supported by a range of other professionals; relatives confirmed this. However, we were made aware of some delays to following some professionals' advice or a lack of knowledge.
● An example of delay was in getting sensor equipment in place for one person. No one had come to harm as a result of this, however improvements were needed.
● One professional told us, "There is a new team now, they are unfamiliar with background of residents. There is a lack of communication and handover."
● Multiple professionals told us they felt other ways of supporting people or other reasons for why people had distressed or changed behaviours were not always explored, prior to resorting to medicines.
● This did not follow the principles of STOMP guidance, 'Stopping over medication of people with a learning disability, autism or both'. It is a national project to stop the overuse of psychotropic medicines. Psychotropic medicines affect how the brain works. One professional said when talking to a member of the management team, "They were more accepting of the advice, but had a limited understanding of STOMP."
● Despite this, relatives did not raise any concerns about the use of medicines and we acknowledge the provider was working in partnership to have people's medicines reviewed.

Adapting service, design, decoration to meet people's needs
● Improvements were needed to the personalisation of the home; however, plans were already in place to achieve this. This included having individual murals in people's bedrooms and more personalised photos.
● One person had not had curtains for months. The registered manager explained this was because they thought the person would pull them down a lot. The registered manager explained they had already arranged a company to come and resolve this. Despite this, the person did have privacy glass on their bedroom window, so their dignity would not be compromised.
● The environment did not have personal items on display; however, this was explained as people could sometimes damage their items.
● The building was safely maintained as checks were made on safety, such as gas, electrical and fire safety equipment checks.
● CCTV cameras were in place in communal areas of the bungalows. Appropriate assessments and registration of this was in place.

Supporting people to eat and drink enough to maintain a balanced diet
● People received support to eat and drink enough to maintain a balanced diet, in line with their needs. One relative said, "The meals are freshly cooked, my relative can have what they want."
● Plans were in place to guide staff if people needed supporting in a particular way, or if someone's food and fluids needed monitoring.
● People were weighed regularly to ensure they remained healthy.

Ensuring consent to care and treatment in line with law and guidance
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 Act 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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- DoLS applications had been submitted and professionals had reviewed and assessed these. No one was subject to any conditions on their DoLS.
- Details of restrictions to people had been included as appropriate.
- People were supported to make choices, such as what time they could get up or go to bed and food choices. One relative said, "I think my relative has a choice with clothes and food." One staff member said, "If [person's name] doesn't like something they will push it away."

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 good. At this inspection this key question has now deteriorated 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.

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 a positive culture in the service. It was acknowledged the prolonged COVID-19 pandemic had impacted staff morale, as well as staff turnover and changes to management teams. The registered manager had already recognised staff morale needed improving prior to our inspection. The provider had also recognised improvements were needed.
- Staff did not feel empowered and did not feel able to openly report concerns. There was not a culture of learning following incidents and staff were not always appropriately skilled at supporting people during periods of distress, due to lack of effective training.
- Communication was not always effective to ensure people, relatives and staff were fully engaged in the service.
- One staff member said, "I don't feel I know what I am doing. There is no communication, I feel really lost." Another staff member said, "I feel we just get shut down [when trying to feedback]."
- The provider explained training had been paused due to the pandemic and staff absence during the COVID pandemic sometimes affected staff availability to complete training. However, other ways staff could be supported to continue to learn and improve in the meantime had not been fully explored. This meant some staff had been left without training and not feeling confident in their role.
- Following the lifting of some COVID restrictions, the provider had established a plan to ensure staff completed training.
- As people were not always fully supported by staff who were skilled in different methods of communication, other than verbal communication, we could not be sure people were fully engaged in the service.

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

- Monitoring systems in place had not been effective at checking the quality and safety of the care being delivered.
- Whilst we found no one had come to harm as a result of medicines procedures, they required strengthening. The registered manager explained staff did a daily check on medicines however this had failed to identify the expired medicine and the lack of up to date PRN protocols.
- The registered manager explained they themselves did not currently do any checks on medicines; they

said, "That is something I am going to put in place. Due to COVID-19 it has been a bit hectic. It has been unprecedented times. I'm going to do an audit on medicines every month."
● We found and professionals also shared that records were not always detailed. One professional said about records when people were distressed, "It is quite brief, they [staff] just put 'agitated' but do not describe it. They were not recording what they were trying [to help someone calm down]."
● The registered manager was not aware of the 'Right support, right care, right culture' guidance which guides services in supporting people with a learning disability and/or autism.

The above concerns show quality assurance systems had not been fully effective at ensuring the quality and safety of the service was monitored and improved. This constituted a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Continuous learning and improving care
● The registered manager was clear about their responsibility for duty of candour. They said, "It is about being honest, having integrity, not holding anything back if anything has gone wrong."
● However, as multiple incidents had not always been reported to the safeguarding authority and it had not been recorded that incidents had been reported to the relevant people, such as relatives, we could not be sure duty of candour was always being followed.
● Notifications were not always submitted as required. A notification is information about events that by law the registered persons should tell us about, such as allegations of abuse, serious injuries and deaths. There were some safeguarding allegations the registered manager had referred but we had not been notified of these.

Working in partnership with others
● The service worked in partnership with other organisations and professionals to support people.
● Whilst improvements were needed in communication and the culture of the service were needed, the management team were open to feedback and proactive at responding to concerns identified.
● One professional said, "[The registered manager] said they would work with us." Another professional said, "[Registered manager] seemed to want to help and change things." The registered manager told us about working with others; "I will listen, I am happy to take advice on board. I want to soak up all that knowledge. I am adaptable."
● The provider had requested multi-agency reviews of peoples' needs to ensure they are appropriately supported. It was acknowledged the service felt they had experienced some difficulty in accessing input from some professionals during the pandemic which they felt impacted on some care and support for people.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding referrals were not always being made to the local safeguarding authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not always effective at monitoring the quality, safety and culture of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always have the training and skills to effectively support people and feel confident in their role.