

Mr & Mrs B H & J L Koomar

Langlea House Care Home

Inspection report

Langlea Terrace
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Date of inspection visit:
19 September 2018
24 September 2018

Date of publication:
31 October 2018

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 19 and 24 September 2018. The first day was unannounced; the provider knew we were returning on the second day.

Langlea House 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 home provides nursing and personal care for up to 14 older people, some of whom may be living with dementia. Accommodation is provided on two floors with chair lift access between floors. There are communal areas on the ground floor, including a lounge, conservatory, dining room and visitors room. There were 10 people in the home when we inspected including one person who was in hospital.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission 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 2008 and associated Regulations about how the service is run.

At our last inspection on 14 March 2016 we rated the service as 'Good' and there were no regulatory breaches. At this inspection, we have rated the service as 'Requires Improvement'. Although we found some aspects of the service were good, we found others required improvement. This was in relation to recruitment processes, record keeping and quality assurance systems. We identified two breaches of regulation; Regulation 19 (Fit and Proper Persons Employed) and Regulation 17 (Good Governance).

Staff recruitment procedures were not robust as thorough checks had not always been completed before staff started working in the service. Staff received the induction, training and support they required to carry out their roles.

Staff had received training in safeguarding and understood the reporting systems. Safeguarding incidents were reported to the local authority safeguarding team. Staff were aware of how to manage risks to people, however this was not always fully reflected in risk assessments which required more detail.

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

There were sufficient staff to meet people's needs. People and relatives were happy with the service provided. They said staff were kind and caring and respected people's privacy and dignity. People's nutritional needs were met and people had access to healthcare services.

Activities were provided and opportunities to go out which people told us they enjoyed. Systems were in place to manage any complaints.

People received personalised care and staff were kept informed of any changes in people's needs through handover at each shift change. However, people's care records were not always up to date or accurate and there was not enough detail to guide staff about the care and support people required. Medicine management was safe, although some improvements were needed in relation to record keeping.

People, relatives and staff praised the management of the home. The registered manager had already identified improvements were needed and an action plan was in place. New care documentation had been developed and was due to be in place by December 2018. The quality audit systems and processes needed to improve to enable the provider to effectively assess, monitor and improve the service.

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

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.

Medicines management was safe and effective, although some improvements were needed in record keeping.

Staffing levels were sufficient to meet people's needs in a timely manner. Staff recruitment checks were not always thorough.

Risks to people's health, safety and welfare were assessed and mitigated, although not always fully reflected in the records. Safeguarding incidents were recognised, dealt with and reported appropriately.

Is the service effective?

Good ●

The service was effective.

Staff received the induction, training and support they required for their roles.

The service met the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were met. People had access to healthcare professionals.

Is the service caring?

Good ●

The service was caring.

People told us the staff were kind and caring and this was confirmed in our observations.

People were treated with respect and their privacy and dignity was maintained.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Personalised care was delivered however, care records were not

always accurate or up to date and did not reflect people's current needs.

Activities were provided and also opportunities for people to go out.

People knew how to raise any concerns and a complaints procedure was in place.

Is the service well-led?

The service was not always well-led.

Systems in place to assess, monitor and improve the quality of the service were limited and needed to be developed further to ensure service improvement.

People, relatives and staff provided positive feedback about the way the service was run and praised the leadership and management.

Requires Improvement 

Langlea House Care Home

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 checked 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 19 and 24 September 2018. The first day was unannounced and one inspector and an expert by experience with experience of services for older people attended. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day was announced and one inspector attended.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made judgements in this report.

We observed how care and support was provided to people. We spoke with eight people who were using the service, two relatives, five care staff, the provider, the maintenance person and the registered manager.

We looked at two people's care records, four staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Is the service safe?

Our findings

People told us they received medicines when they needed them. One person said, "I get my medication on time."

We checked seven people's medicine administration records (MARs). The majority of the MARs were well completed and showed people had received their medicines as prescribed. However, for two people there were no signatures on the MAR to show one of their morning medicines had been given. This was a recording issue as when we checked the stock we found these medicines had been administered. Another person's MAR showed one dose of two medicines had not been signed as given and these medicines had not been administered. There was no reason recorded as to why the medicines had not been given and neither the staff member or registered manager knew why. The person had not come to any harm as a result of not receiving these medicines. The registered manager told us they would look into this matter and address it with the staff.

People were prescribed medicines to be given "when required", however there was no information recorded to guide staff in how to administer medicines prescribed in this way. We found where people were prescribed a variable dose, the actual dose administered was not recorded. Where medicines required a time gap between doses the actual time of administration was not recorded on the MAR. This meant that people prescribed medicines in this way were at risk of not being given them safely or consistently. On the second day of the inspection the registered manager showed us protocols they were putting in place for people who were prescribed 'as required' medicines.

The registered manager told us of ongoing problems they were experiencing with the pharmacy they used. This included some medicines not being received and printed MARS not containing the correct information. We saw evidence which showed the registered manager had raised these issues with the pharmacy. A pharmacist from the clinical commissioning group (CCG) was also liaising with the registered manager and pharmacy to help resolve these matters.

Safe systems were in place for the ordering, receipt and return of medicines. Medicines were stored securely and at the right temperature so they did not lose their therapeutic effect. The registered manager told us one person had one of their medicines given covertly (hidden in food or drink). A mental capacity assessment and best interest decision was recorded. The medicine care plan gave instructions on how the medicine should be administered covertly and there was evidence to show a pharmacist had been involved in these instructions.

We found staff were aware of the risks to people and we saw action had been taken to mitigate the risks and keep people safe. For example, the use of bed rails to protect a person from rolling out of bed and the use of sensors where people were at risk of falling. Risk assessments were recorded in people's care records in relation to areas such as falls, mobility, nutrition and continence. However, we found some of these lacked detail and were not always up-to-date. For example, there was no information in one person's mobility risk assessment about the type of hoist they required or the size and type of sling. We concluded the issues

around medicines and risks demonstrated inaccurate record keeping and this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had already identified improvements were needed to the care documentation, which included risk assessments. We saw the new care documentation templates the registered manager was putting in place and an action plan showed this would be completed by December 2018.

We found recruitment processes were not always safe. We looked at three staff files. All had completed application forms and references and criminal record checks had been obtained. However, one care worker started in post in April 2018, yet their criminal record check had not been received until May 2018. For another staff member, the surname on their criminal record check did not match the surname on their identity documents. The registered manager acknowledged they had not identified this when checking the documents and said they would follow it up with the staff member concerned. We found references had not always been verified and it was not always clear in what capacity the referee knew the person. This was a breach of the Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe in the home. Comments included; "I feel safe even when I'm on my own" and "Oh yes very much safe here." Relatives said, "My (relative) is absolutely safe and well cared for" and "My (relative) is 100% safe."

Staff had received safeguarding training and had a good understanding of safeguarding and whistleblowing procedures. Staff said they would not hesitate to report concerns to the registered manager. We saw the registered manager had made appropriate referrals to the local authority safeguarding team when this had been needed. This meant staff understood and followed the correct processes to keep people safe.

We found there were sufficient staff to meet the needs of people currently accommodated in the home. We observed staff maintained a presence in communal areas and were available and responsive to people's needs.

Most people we spoke with felt there were enough staff to provide the care and support they needed. Comments included; "I would have thought there's enough staff" and "There is enough staff they do very well." One person said they thought the home, "Occasionally could do with a little more staff" and another person said they felt the home was 'short staffed'.

The registered manager told us they kept staffing levels under review and increased them if people's needs changed. They said the usual staffing levels were three care staff on duty between 7am and 9pm. Between 9pm and 7am there was one care worker on duty and the registered manager, who lives next door to Langlea House, was on call overnight. This was confirmed in the duty rotas we saw. We noted the duty rotas did not include the full name of the staff or their role. This needs to be addressed to ensure a complete and accurate record is maintained of who is working and in what capacity.

The registered manager and staff told us nine of the ten people living in the home required only one staff member to assist them. One person required two staff when using the hoist to transfer during the day. Staff who worked nights told us this person's care needs could be managed safely by one staff member overnight as the person was able to move themselves independently in bed. Staff said on occasions when the person was unwell and unable to move themselves they contacted the registered manager who responded quickly and came in to assist. The registered manager told us they were in the process of recruiting more night staff so they could have one waking night staff member on duty and one care worker sleeping-in who could provide support as and when needed. The registered manager told us they were looking at implementing a

dependency tool to assist them in calculating safe staffing levels.

We saw up to date records relating to safety checks of the premises, for example in relation to operation of equipment, gas safety, electrical wiring, water storage and fire alarm testing.

Staff followed good infection control practices. People and relatives told us the home was kept clean and this was confirmed when we looked round the premises. We observed hand washing facilities were available and staff were provided with gloves and aprons to use to help prevent the possible spread of infection.

Personal emergency evacuation plans (PEEPS) were in place and these were up to date. Fire alarm testing was carried out weekly and fire drills were held regularly. This meant staff knew what action to take should an emergency situation arise. The maintenance person told us the fire authority had visited the home recently and were satisfied with the fire safety arrangements in place.

We saw accidents were recorded and the registered manager showed us a monthly falls analysis they had recently implemented. Their plans were to use this analysis to look at lessons learnt and share that learning with staff with the aim of improving safety as much as possible.

Is the service effective?

Our findings

People's needs were assessed before they moved into the home. The registered manager told us when an initial enquiry was made the person was invited to come for lunch at the home. They said this gave the person an opportunity to meet other people living in the home and the staff in a relaxed and sociable setting and meant they could look around and ask any questions. The registered manager said as Langlea House was a small home it also meant people already living there could have a say in any new admissions.

The provider ensured staff received the training required to effectively care for people. The registered manager told us all new staff spent the first week shadowing senior staff and then completed an induction and the Care Certificate. This was confirmed in our discussions with staff and on the training matrix.

Staff spoke positively of the training they received which they said was kept up to date. The training matrix showed the majority of staff were up to date with training the provider deemed as mandatory such as fire safety, safeguarding and moving and handling. Dates for refresher training were highlighted on the matrix so the registered manager could ensure staff were completing necessary updates. Specialist training had also been completed covering topics such as Parkinson's awareness, sensory awareness and wound care. The registered manager told us they had recently introduced staff champions to take the lead and provide support to staff on specific topics such as medication and safeguarding. We spoke to the medicine champion who was enthusiastic about their role and told us how they were working with other agencies to gain knowledge and make improvements.

Staff received regular supervision and an annual appraisal with the registered manager. This was confirmed in our discussions with staff and review of records.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met.

The home was working within the principles of the MCA. Two people had DoLS authorisations in place; neither had conditions attached. Staff had received training in the MCA and DoLS and were aware of the DoLS authorisations in place. We heard and saw staff explain what they were doing and checked to ensure people understood and agreed before proceeding. One person's records showed a relative had lasting power of attorney (LPA) and the relative had signed consent forms for the person's care and treatment.

However, documents showed the LPA was for property and affairs and not for health and welfare. LPA is a legal document that lets a person (the 'donor') appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. There are two types of LPA; one for health and welfare, the other for property and financial affairs. The registered manager had identified this and was arranging to meet with the relative to discuss the matter.

People were supported to have a good diet which met their nutritional needs and preferences. People told us they enjoyed the food. Comments included; "The food is good"; "Generally the food is okay" and "Yes I like the food here."

We spoke with one of the providers who was doing the cooking as they were in the process of recruiting a new chef. We saw menus were displayed in the dining room and followed a fortnightly rota. There was a choice of meals and we saw the provider asking people mid-morning what they would like for lunch. All the meals were homemade, including a pie containing fruit one of the relatives had brought in from their garden.

Lunchtime was a relaxed and sociable occasion with staff available to provide people with the support they needed. Tables were set with tablecloths, cutlery, crockery and condiments. People were offered hot and cold drinks. The food was nicely presented and looked and smelt appetising. We saw drinks and snacks were offered between meals.

People's healthcare needs were met and the provider worked with other healthcare professionals to maintain continuity of care for people. Care records indicated appropriate referrals to healthcare professionals such as the GP, district nurse and podiatrist had been made. The home had recently installed a system called telemonitoring which allows people who use the service and staff to access out-of-hours doctors via a live video link with the aim of reducing hospital admissions.

The environment was homely and personalised with photographs and pictures. The communal areas were comfortably furnished with easy chairs and small tables. There was access to the garden and patio areas through the conservatory. Large clocks were displayed, one of which gave the date and information about the weather. Pictorial signs showed where bathrooms and toilets were located. Individual photographs on doors helped people find their bedrooms. In the PIR the provider told us they were working with the dementia alliance group and attended local meetings every two to three months to exchange ideas, promote good practice and improve the lives of people living with dementia, which included providing a safe environment.

Is the service caring?

Our findings

People spoke highly of the staff describing them as kind and caring. Comments included; "The staff are very kind, I've no complaints"; "The staff do their best" and "The staff are kind and never object to anything."

Relatives we spoke with were equally positive about the staff and care provided. One relative said, "All the staff go above and beyond. All is good here, it's excellent." Another relative said, "I feel at home here with my (relative). It's like one big family."

We observed staff were caring and compassionate in their interactions with people. Staff clearly knew people well. They were attentive and noticed when people were alone or quiet and checked the person was all right. Staff told us one person liked a particular type of music and that they liked to listen to this when in their room. In the afternoon when the person was in their bedroom we heard this music playing.

There was a happy and friendly atmosphere. People looked relaxed and comfortable around staff and there was lots of chat and laughter. One person who had been having a laugh with a staff member said to us, "She's lovely her, makes me laugh. I keep telling her she works too hard." We saw when relatives visited they were warmly welcomed by staff and offered a drink. One relative told us, "I'm always made to feel welcome."

People were treated with respect and their privacy and dignity was maintained. We saw staff supported people with their appearance, ensuring they were clean, comfortably dressed and well groomed. People's bedrooms were personalised reflecting individual tastes and interests. Any personal care was carried out in private. We saw staff knocked and announced who they were before entering anyone's room.

People were encouraged and supported to maintain and develop their independence. We saw staff encouraged people to mobilise and encouraged them to do as much for themselves as possible. During our visit one person wanted to go out for a walk even though it was very windy and wet outside. The registered manager helped the person wrap up and then they went for a walk outside. When they came back in the person was smiling and said how much they had enjoyed being in the fresh air although it was 'very windy'.

We looked at whether the home complied with the Equality Act 2010, and in particular how the home ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Our observations of care, review of records and discussions with the registered manager, staff, people and relatives showed that discrimination was not a feature of the service.

Is the service responsive?

Our findings

People and relatives told us they were happy with the care provided. Comments included: "All is good here. I wouldn't be here if not"; "I need looking after but I can make my own choices" and "All my (relative's) needs are met. They are looking after (relative) tremendously and listen to what (relative) says."

We observed staff delivered personalised care that was responsive to people's needs. Our discussions with staff showed they had a good understanding of the support people required. Staff confirmed they were kept informed of any changes to people's care needs through the shift handover process.

However, we found the care records we reviewed were not always accurate or up to date and it was not always easy to determine people's current needs. For example, there was contradictory information about one person's mobility with one care record stating the person was unable to walk and another stating the person could walk short distances with staff. Some records were not dated or signed by staff. Records about people's care needs were kept in different folders rather than in one file which made it difficult to gain an overall picture of the care and support each person required. We concluded these issues demonstrated inaccurate record keeping and this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the PIR, the provider stated, "We are making changes to our care plans to make sure they are more person centred." At the inspection the registered manager acknowledged the shortfalls in care records. They told us they had reviewed many different care documentation templates and showed us the ones they were proposing to implement which they said would be in place by December 2018.

One person was receiving end of life care. We spoke with their relative who was very happy with the care provided. They said, "My (family member) is on end of care life and I asked if music could be played at (their) bedside and they have got it all in place for (them). All is good here it is excellent." We saw this was reflected in the person's care records. The registered manager told us some of the staff had received training in end of life care and those who hadn't would be attending the training.

People told us about the activities in the home. One person said, "A gentleman singer and dancer comes here and he always picks me. I do everything and sing lovely old songs with him." Another person told us, "I join in all the activities. I have a go at everything." Several people mentioned the children who visited each week from a local nursery school and said how much they enjoyed seeing them. One person said, "I love to see the little ones come." People also told us they went out. One person said, "I love to sit in the garden and nearly always someone comes to sit with me." Another person said, "If I need anything I go to the shops."

A relative whose family member was receiving end of life care told us, "They try and keep (family member) active. A lovely thing is when they are decorating buns they push (family member) in the wheelchair to sit with the others doing their buns so (family member) is still part of it."

Forthcoming activities and events were displayed on the noticeboard in the home. These included a

MacMillan coffee morning, a bonfire night display, a curry night and a Christmas fayre. Staff told us there was also a weekly exercise class, arts and craft sessions and memory quizzes.

People told us if they had any concerns they would raise them with staff and felt these would be dealt with appropriately. One relative said, "If there was any issues I would e-mail the manager and it would be sorted out straight away." No-one we spoke with had concerns at the time of our visit.

The complaints policy had recently been updated and was displayed in the home and also contained in the service user guide. We saw three complaints had been received since our last inspection. All three had been investigated and responded to appropriately. The complaints were all recorded in a book, however the registered manager showed us a new complaint form they had put in place to record any new complaints and to ensure the home was meeting data protection requirements.

Is the service well-led?

Our findings

People, relatives and staff spoke positively about the management of the home. However, we found improvements were required in relation to quality assurance systems and processes, recruitment processes and care documentation.

There were a limited number of quality audits in place which did not cover all aspects of service delivery. We saw weekly and monthly medicines audits, environmental audits and infection control audits. However, we found the recording of these needed to improve. For example, not all sections of the medicine audits were completed and where issues had been identified there was no action plan or timescale to show when these would be addressed or who was responsible. The registered manager told us there were currently no care plan audits but said they were planning to introduce these when the new care documentation was in place.

The registered manager told us the views of people who used the service, their relatives and healthcare professionals were sought through questionnaires sent out in February. We saw the results of the questionnaires had been collated and a summary of the outcomes was displayed in the home. However, there was no breakdown to show who the responses had come from, for example, how many were from relatives or healthcare professionals.

We found the quality assurance systems were limited and needed further development and embedding to ensure continuous service improvement. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager had completed the provider information return (PIR). This showed the registered manager was aware of the areas the service performed well at and where they planned to make improvements. An action plan was in place which identified improvements to be made and timescales for completion.

People we spoke with all praised the management of the home. Comments included: "The manager is fantastic. There is nothing to improve here"; "(The manager) runs a very nice establishment"; "(The manager) is always interested in us here" and "I like everything here. I wouldn't change anything. I have never felt I couldn't ask anything." Relatives were equally positive and described the registered manager as 'approachable'.

Staff told us they enjoyed their jobs. They said they worked well together as a team and felt communication was good. They said regular staff meetings were held where they could raise any issues and put forward suggestions. Staff told us they were well supported by the registered manager. All the staff we spoke with said they would recommend the home as a place to work and would also recommend the service to people who needed care. One staff member said, "It's so homely here and welcoming. We're like a big family and if my mum and dad had to go in somewhere I'd want it to be like this."

Dates of residents' meetings were displayed in the home. We saw minutes from the last meeting on 23 September 2018 where the CQC visit, activities and food were discussed.

There were CCTV cameras in place outside the building on all exits and entrances and in the dining room, lounge, hallway and kitchen. We saw documents in people's care files informing them about the purpose and usage of this equipment which showed people had given consent. Notices were displayed in the entrance to the home and the provider had completed a privacy impact assessment which provided detailed information about the use of this equipment.

The previous inspection ratings were on display in the service as required under legislation.

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	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (1) (2) (b) (c)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>Recruitment procedures had not been established and operated effectively to ensure that persons employed were of good character and had the qualifications, competence, skills and experience which are necessary for the work to be performed by them Regulation 19 (1)(a)(b)(2)</p>