

Langford Park Ltd

Langford Park

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 caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

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

Langford Park is registered to provide accommodation, nursing and personal care support for up to 34 older people, people living with a dementia and younger people with a physical disability. At the time of this inspection there were 29 people living there.

At inspections in 2016 and 2017 the service was rated as Requires Improvement. We inspected the service in 2018 and found that improvements had been made, therefore the service was rated Good.

However, at this inspection in August 2018, we found that the improvements had not been sustained. Aspects of the management and recording of people's medicines now required improvement. Care plans did not consistently contain the guidance staff required to administer medicines safely, and when required. A member of staff was wearing a tabard to indicate they were doing the drugs round and should not be interrupted, but was undertaking other tasks. The manager was aware of the concerns and at the time of our inspection additional training in medicines administration had been arranged. In addition, a new clinical lead had been employed, along with two new nursing staff.

People did not always have the opportunity to engage in activities and social stimulation. Although some activities did take place, there was no activities programme. People told us they were bored and lonely. Two relatives told us their family member was becoming increasingly depressed and withdrawn because they were not receiving the support they needed to stimulate their mind or participate in activities. The manager was aware of this concern and action was being taken to address it. Two new activities co-ordinators were being recruited to work alongside the existing activities co-ordinator. The importance of interaction with people was being emphasised to staff.

Significant changes in the management structure and staff team had undermined the quality and safety of the service. These changes were intended to improve the service and provide better consistency, however at the time of the inspection they were not fully embedded. Many of the new staff had not worked in a care home before. They had not received the induction, training and supervision required to do their roles effectively. There were concerns about poor recording, decreasing standards of personal care and housekeeping, and a lack of clarity around roles and responsibilities. The provider had identified these issues through their quality assurance processes, and developed an action plan to address them. Emergency staff meetings had been held with clear guidance given to staff about expectations and the action required.

People told us they felt safe. Regular health and safety checks were undertaken at the service. There were effective infection prevention processes in place, the home was compliant with fire regulations and a

programme of refurbishment was in progress. People were protected from the risk of abuse through the provision of policies, procedures and staff training, and an effective recruitment process.

There were systems in place to ensure risk assessments were comprehensive, current, and supported staff to provide safe care while promoting independence. The computerised care planning system, accessed by staff using handheld computers, ensured that information about people's risks was shared efficiently and promptly across the staff team. This meant staff had detailed knowledge of people's individual risks and the measures necessary to minimise them.

Care plans were person centred and provided clear guidance for staff which enabled them to meet people's needs according to their preferences. They had not always been formally reviewed in line with the provider's own policy, however they had been updated as required and the information therefore remained current.

Staff had a clear understanding of the process for managing and reporting accidents and incidents and were using it effectively. Information was reviewed and analysed by the management team, and action taken where required, to prevent reoccurrence.

Staff promoted people's independence and treated them with dignity and respect. They were familiar with people's history and backgrounds, respected their choices and acted in accordance with their wishes. People were accepted for who they were regardless of their sexuality, faith or culture.

People were supported to make choices about their day to day lives, for example how they wanted their care to be provided and how they wanted to spend their time. The service ensured people and their advocates where appropriate, were fully consulted and involved in all decisions about their lives and support. Staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. Where people lacked capacity, mental capacity assessments were completed and best interest decisions made in line with the MCA. This meant people's legal rights were protected.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. They had made appropriate applications for people they had assessed that required to be deprived of their liberty to the local authority DoLS team.

People had sufficient amounts to eat and drink and received a balanced diet. Care plans guided staff to provide the support they needed. The service worked with the speech and language therapists (SALT) team, to meet the needs of people with swallowing difficulties. People spoke positively about the food and choices available.

Staff made prompt referrals to relevant healthcare services when changes to health or wellbeing had been identified. The service worked closely with health and social care professionals to ensure people's health needs were met. We spoke to visiting health professionals during the inspection who spoke positively about the responsiveness and effectiveness of the service.

The service was moving towards specialising in end of life care. People were often discharged to Langford Park from hospital at short notice. The service worked closely with health and social care professionals to ensure people's needs and preferences were understood and met, and they and their families were supported at the end of their lives.

The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Although we were given some examples of good practice in this respect, and there was a specific policy in place, there was a lack of consistency in care plans to guide staff. The manager advised they would make the necessary improvements to ensure compliance with the Standard.

People knew how to make a complaint and told us they had confidence in the complaints process. The provider was using the complaints policy effectively to address some concerns raised by family members.

Despite the management team being highly visible at the service and staff telling us they were well supported, there was not always effective monitoring and accountability to help ensure the ongoing quality and safety of the service.

People, relatives and staff were invited to express their views of the service through satisfaction surveys, interviews and at meetings. The information from the quality assurance processes was used to drive improvements at the service.

We found four breaches of the regulations. You can see the back of the full report to show what action we have told the provider to take.

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.

Peoples medicines were not always managed safely.

People were supported by adequate numbers of staff. However, the quality and safety of the support had been affected because of significant changes to the management and staff team.

People had individual risk assessments in place to help keep them safe.

People were protected from avoidable harm and abuse. Systems were in place to ensure the environment was safe for people.

Is the service effective?

Requires Improvement ●

The service was not always effective.

People were not always supported by staff with the skills and knowledge to meet their needs.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and promoted choice and independence whenever possible.

People's eating and drinking needs were known and supported.

People's health needs were met and staff worked closely with a range of health staff to achieve good outcomes for people.

Is the service caring?

Good ●

The service was caring.

Staff were kind and compassionate and treated people with respect.

Staff supported people to improve their lives by promoting their independence and wellbeing.

Equality and diversity was respected and people's individuality

supported.

People were supported to maintain on-going relationships with their families and were able to have visitors at any time.

Is the service responsive?

The service was not always responsive.

People did not always receive the support they needed to stimulate their mind or participate in activities.

People had comprehensive care plans which gave staff the information they needed to meet their needs.

People and their relatives knew how to make a complaint and raise any concerns.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

People lived in a service which was not effectively monitored and assessed to help ensure its ongoing quality and safety.

The quality and safety of the service had been jeopardised by the way in which changes in management and staffing had been introduced.

The provider and management team were open and transparent and were committed to improvement.

People, staff and relatives told us the registered manager and provider were accessible and responsive.

The provider and manager were clear about how they wished the service to be provided and worked to ensure their vision and values were understood and shared by the staff team.

Requires Improvement ●

Langford Park

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 comprehensive inspection took place on 09 and 10 August 2018. The inspection was unannounced and was carried out by an adult social care inspector 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. The expert by experience on this inspection had experience of working with and supporting older people.

Prior to the inspection we reviewed the information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We met and observed the majority of the people who lived at the service and received feedback from 12 people. Not everyone was able to verbally share with us their experiences of life at the home due to their dementia/complex needs. We therefore 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 also spoke with four relatives to ask their views about the service. We spoke to 13 staff, including the provider, manager, deputy manager, cook, housekeeper, team leaders, care staff and activities co-ordinator. We also spoke with two visiting health and social care professionals.

We reviewed information about people's care and how the service was managed. These included 15 people's care records and medicine records, along with other records relating to the management of the service. These included staff training, supervision and appraisal records, five employment records, quality

assurance audits and minutes of relatives and staff meetings.

Is the service safe?

Our findings

At our inspection in June 2017 there were concerns about people's safety, and we found a breach of the regulation relating to people's safe care and treatment. At the inspection in January 2018 we found improvements had been made and the rating for this key question improved to Good. However, at this inspection we found improvements had not been sustained. Therefore, the rating is now Requires Improvement.

Aspects of the management and recording of people's medicines required improvement. Care plans did not consistently contain the guidance staff required to administer medicines safely and when required. For example, the care plan of a person living with diabetes did not indicate what their blood sugar level should be and when, and how their emergency medicine should be administered. Care plans did not provide specific personalised care instructions for administering 'as required' medicines, such as for the relief of pain. They did not consistently contain detailed guidance for the maintenance and cleaning of medical devices such as a nutritional pump and tracheostomy equipment, necessary for infection prevention.

A member of staff was wearing a tabard to indicate they were doing the medicine round and should not be interrupted. This was to allow them to focus on the task and give people their medicines correctly and safely. However, they wore the tabard throughout the day when undertaking other tasks. This meant it was unclear whether they could or could not be interrupted and could lead to a distraction when they were administering medicines.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns with the manager. They were aware of the need for improvements in medicines administration and training, and told us, "It's not unsafe, and not as good as I want it to be." Action was already being taken. Senior staff were periodically observed to ensure their competency. Additional training and one to one sessions were being arranged. In addition, a new clinical lead was in post, along with two new nursing staff.

Although the service was fully staffed, there had been significant changes to the management structure and staff team. This was largely due to promotion within the service and the recruitment of ten permanent staff to replace agency staff. Although these changes were intended to improve the service and provide better consistency, at the time of the inspection they were impacting negatively on the quality and safety of the support provided.

An audit had identified concerns including poor recording, decreasing standards of personal care and housekeeping, and a lack of clarity around roles and responsibilities. As a result of this, emergency staff meetings had been held and the concerns addressed, with clear guidance given to staff about expectations and the action required. The manager described it as a "stressful, time consuming blip", saying "We took the whole of the structure away apart from a few team leaders...We're going to take charge of this again. We

take full responsibility, we've thrown people in at the deep end."

Many of the new staff had not worked in a care home before. Existing staff told us they had needed more support with the computerised care planning system and recording. For example, people's fluid intake had not been recorded properly which was a concern during very hot weather. The manager told us everybody at the service had now been placed on a 'fluid watch' chart to record their fluid intake over a 24-hour period. They had made sure all staff knew how to complete it. One person confirmed, "They made us drink more during the very hot weather. They measured input and output".

Confusion over roles and responsibilities had impacted on the availability of staff to meet people's needs. People told us staff were often rushed, or slow to answer their call bells. Other comments included, "They do understand my needs but I need two people to move me and two are not always available" and, "They do respond to requests but sometimes they forget if someone else talks to them in between." This issue had been addressed at a series of emergency meetings where roles and responsibilities were discussed and clarified.

People identified as nutritionally vulnerable had been weighed, as well as people on pressure relieving mattresses in order to obtain the correct setting for their weight. Of the eight mattresses we looked at however, seven were at the wrong setting for the recorded weight. Despite this there were no people at the service with a hospital or nursing home acquired pressure ulcer. Concerns about the checking of mattress settings had been identified in an audit prior to the inspection, and were being addressed with staff.

Overall, people and their relatives felt it was a safe service. Comments included, "They look after me well here. I do feel safe. I always have two carers to help to get in and out of bed."

I don't feel any fear of anything here. I'm alright" and, "I feel my [relative] is safe here. I used to care for them at home but they needed more".

There was a computerised care planning system at the service, which was accessed by staff using hand held devices. It enabled the management team and shift leaders to have immediate oversight of the support being provided by staff, and any issues or concerns. Information from the person's initial assessment and current assessment of risk was fed through to the person's care plan. This meant staff could easily access the information and guidance they needed to provide safe and effective care.

Risk assessments were comprehensive and updated monthly or when people's needs changed. These included risk assessments for moving and handling, skin integrity, bed rails, nutrition, health and safety or when people had behaviours that were challenging. The system also prompted staff to undertake the tasks required to keep people safe by anticipating people's needs and intervening when they saw any potential risks. For example, the risk assessment for a person at risk of absconding guided staff to ensure the person was observed when mobilising along corridors, ensure the door alarm to fire escape was set to emergency if opened, and to support the person to go outside for a walk two or three times day so they would be less likely to want to leave on their own.

The service protected people from the risk of abuse through the provision of policies, procedures and staff training. Staff had undertaken training in safeguarding vulnerable adults. This meant they had a clear understanding of what abuse was and how to report any concerns both internally and externally to outside agencies. There was a whistleblowing policy in place, which meant staff could raise concerns anonymously and without prejudice. Staff told us they had used it and it worked 'extremely well. They were listened to, taken seriously and action had been taken. The service had worked closely with the local authority

safeguarding team and commissioners to investigate safeguarding concerns and take any action necessary to keep people safe.

Risks of abuse to people were minimised because the registered manager ensured all new staff were thoroughly checked to make sure they were suitable to work at the home. Staff recruitment records showed appropriate checks were undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all records. The DBS checks people's criminal history and their suitability to work with vulnerable people. There were also disciplinary procedures in place, which had been used effectively to address concerns about poor staff practice and maintain the quality and safety of the service.

People were kept safe from the risk of emergencies in the home. There were emergency plans in place so that people would be supported in the event of a fire or other emergency. Each person had a personal emergency evacuation plan (PEEP) to show what support they would need, with a photograph so that they could be identified. This meant staff and the emergency services would easily be able to find information about the safest way to move people quickly and evacuate them safely. Staff had received training in fire safety, and fire checks and drills were carried out in accordance with fire regulations.

Records showed that accidents and incidents had been recorded promptly by staff with the action taken. They had been analysed and evaluated by the management team to identify any wider improvements needed.

Systems were in place to help prevent and control infection. Staff understood what action to take to minimise risks, such as the use of gloves and aprons, and good hand hygiene to protect people. Hand gel, gloves and aprons were readily available. A notice reminded staff and any visitors to put on a disposable apron from the dispenser when entering the kitchen. Clinical waste was disposed of correctly. The management team carried out regular observations of staff to ensure standards were maintained.

The environment was safe and secure for people who used the service, visitors and staff. There were arrangements in place to manage the premises and equipment. External contractors undertook regular servicing and testing of moving and handling equipment, fire equipment, electrical and lift maintenance. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance team.

Is the service effective?

Our findings

At the inspection in June 2017 the rating for this key question was Good, however at this inspection we found areas requiring action. The rating is therefore Requires Improvement.

Overall the service continued to provide effective care and support to people, although people, relatives and staff expressed some concern about the effectiveness of the new staff. Comments included, "Some staff don't know what to do, they just stand around waiting and the real staff don't like telling them". "Some staff are very good and others are rubbish" and "The home is getting right, it depends on which staff are on. There are so many new ones". Other people were more positive, telling us, "It's very nice here. I've been in worse places. They take care of you well. No trouble at all" and, "The nursing care is consistently brilliant. The care is good. The hands-on care goes up and down."

Improvements were required to ensure new staff had the skills, knowledge and experience to deliver effective care and support. Staff who were new to the service told us they hadn't had a proper induction, and had just spent some time shadowing other staff. They told us they didn't know who to go to for support due to changes in the leadership and management team. Some newly recruited staff told us they had not yet completed any training. This meant some staff, who were new to the health and social care sector, were supporting people without having completed key training in areas such as manual handling and safeguarding. Changes in the management team meant that supervision had not been provided in line with the supervision policy.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the issue of staff induction, training and supervision with the manager and provider. The situation had arisen because there were too many new staff starting at the same time, without an established management team to support them. The provider told us, "We are looking into the induction and training. We know it needs to be different. We need to induct people 'en masse' better." A new induction programme was being developed and they were planning for all mandatory training to be completed before new staff started work. This would be followed by two weeks of shadowing, and being mentored for six months by a senior member of staff.

Staff who were not new to the service told us their induction had given them the basic skills they needed to care for people safely. Comments included, "The induction was really good" and, "There was time to sit down and look at care plans."

There was a comprehensive training package. Existing staff were positive about the training. One member of staff commented, "I've done nine on-line courses this year, and face to face courses in moving and handling, oral hygiene and infection control". The training package included both on line and face to face training delivered in a training room on site. The providers mandatory training included safeguarding adults, the Mental Capacity Act, data protection, infection prevention and manual handling. Staff were required to

repeat this regularly to ensure their skills and knowledge remained current. Where people had specific needs specialist training was arranged, such as training about dementia, Parkinson's disease and end of life care. The nurses received specialist training to support them in their roles and were supported with their revalidation as required. Revalidation is a process which helps nurses to demonstrate they practice safely and effectively, and maintain their registration with the nursing and midwifery council (NMC).

Staff were knowledgeable about the people they were supporting, describing their needs and preferences and how they wanted to be supported. For example, one member of staff told us how they supported a person living with dementia, who needed a lot of reassurance and support when receiving personal care. They said, "I try and calm them down. Reassure them. Keep repeating what I am doing." Another said, "I learnt so much about Parkinson's from the Parkinson's nurse. "The [trainer] had gone on to talk to a person at the service living with Parkinson's disease to find out what it was like from their perspective.

People's health needs were monitored and prompt action taken to address any concerns or changes. The service worked closely with health professionals to meet people's medical needs, and care plans clearly referenced their involvement. One visiting health professional told us the service communicated effectively with them, following their guidance. They told us they supported people with complex needs well. Another visiting health professional commented, "They are very responsive. They know their clients well. The care planning has improved. It's a well led service."

The service ensured that people's specific dietary needs were met and their choices respected as far as possible. People's needs and preferences were documented in care plans and well understood by kitchen staff. We observed that staff were attentive to people's needs and offered support with eating and drinking as required.

The cook visited people daily to talk to them about their choice of food. Overall people spoke positively about the quality of the food and the choices available. Comments included, "The food is quite nice. I have whatever I want" and, "I like the food. It's very good and I have a very good appetite. I eat very slowly so they cut the food up for me if necessary and that makes it easier".

The service had worked closely with the speech and language therapist (SALT) team to ensure people received the support they needed to eat and drink safely. The SALT team's guidance was clearly documented in people's individual care records which meant staff had the information they needed to minimise the risks. Staff we spoke to were aware of who might be at risk of choking and the support they needed to keep them safe, for example, thickened fluids or pureed meals.

Staff were aware of their responsibilities under the Mental Capacity Act 2005 (MCA) and how to apply its principles to their practice. The 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.

Care plans demonstrated that assessments of people's capacity to consent to their care and treatment had been assessed and we heard staff consistently asking for people's consent before supporting them. Where a person had been assessed as lacking the capacity to consent, staff had involved people's representatives and health and social care professionals to determine whether a decision was in the person's best interests. These included decisions about finances, the management of medicines and how their support was provided. This ensured people's legal rights were protected.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service had referred people for an assessment under DoLS where required.

Is the service caring?

Our findings

The home continued to provide a caring service for people. People and relatives told us staff were kind and caring. Comments included, "The carers are kind and gentle" and "The staff are very caring, nothing is too much trouble". A new member of staff told us, "It's a nice care home here. They really do care about their residents."

The provider had developed a values framework based on respect for all, trust, professionalism, genuine relationships and excellent leadership. They were working to ensure these values were shared across the staff team. The provider told us in their provider information return (PIR), that "A new set of values have been devised to ensure all staff are working towards the same goal which is to provide outstanding care and to work in a wonderful place. Staff have received training to enable them to understand the importance of the company values."

Staff were proactive in ensuring that people felt accepted and valued for who they were. For example, at the time of the inspection an exhibition of one person's artwork was being assembled for the summer fair. The manager told us, "Everybody is welcome here. Whoever you are, come in! We have no issues with people's sexual preferences or cultural needs. Equality, diversity and human rights is covered in our training. If we heard or saw anybody making derogatory comments we would act immediately to address it."

Care records contained detailed information about people's background and interests, which enabled staff to get to know them and build meaningful relationships. One person said, "They really do care, they remember my quirks and have got to know me personally." The manager told us they aimed to find out people's individual preferences before they came to Langford Park, for example whether they preferred tea or coffee, a bath or shower. They said, "It's good to get as much information as you can then staff can learn about the person beforehand. We try to see the whole person. We tell them, 'This is your new home. It's really sad you've had to leave your old home. Let's make it as good as we can.'"

Staff told us, and we observed, that they treated people with dignity and respect. One person told us, "They always knock on the door and respect my dignity by closing the door and curtains when doing anything personal for me. They are polite and caring". One member of staff said, "I explain what I'm doing and get permission. If I'm supporting somebody to have a wash I cover them with a towel so they feel secure. I make sure the curtains are closed. I start from the top and work down. I wash the top half with a towel on their bottom half so they don't feel exposed. I keep the towel wrapped around their top half while I'm washing their bottom half to keep them warm. I try and make personal care a pleasant experience. I chat with them all the way through."

Staff involved people in their care, promoting their independence and supporting them to make daily choices. For example, they were supported to do as much of their own personal care as they were able, which might be having a flannel to wash their face. One person told us, "I picked a tomato I've grown and gave it to the cook so I had a cheese and tomato sandwich. Other comments included, "I decide when I will go to bed, they ask me and it's usually about 11pm" and, "We are very independent once we are out of bed."

People were supported to maintain on-going relationships with their families and were able to have visitors at any time. They told us, "When I have visitors we are given privacy and the door is closed. Visitors are always offered a drink". Relatives, with the consent of their family member, were able to access the computerised care planning system and view the support being provided to their family member in real time. The system also enabled them to communicate directly with their family members named nurse, and send messages and photographs to the person.

Is the service responsive?

Our findings

At the inspection in June 2017 the rating for this key question was Good, however at this inspection we found areas requiring action. The rating is therefore Requires Improvement.

People did not always receive personalised care that was responsive to their needs, particularly in relation to activities and stimulation. The activities co-ordinator told us there had been an activities programme, but the other activities co-ordinator had left the post two months earlier so this was no longer the case. They told us they spent one to one time with people who stayed in their rooms, reading to them, supporting them with personal care or doing physiotherapy exercises. Other activities included quizzes, reading the paper, colouring and card games. There were also occasional trips to the supermarket and pub. However, during the inspection we observed people sitting for long periods of time with very little interaction with others. People told us they were bored and lonely. Comments included, "There's not much to do here", "The staff very rarely chat with me. I would like to go to the lounge more. I would like to be a happy family. I would like to have my meals with company" and, "I like it here I just want more visitors and to spend more time in the lounge. I get lonely". Two relatives expressed concern that their family member was becoming increasingly depressed and withdrawn because they were not receiving the personalised support they needed to stimulate their mind or participate in activities.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed this issue with the manager who was already aware and concerned about the lack of social stimulation for people living at Langford Park. They told us two new activities co-ordinators were being recruited, and the importance of interaction with people was being emphasised to staff. Staff meeting minutes stated, "Care is not just personal care it is also sitting with someone and having a conversation, or taking them outside. Mental wellbeing is as important as physical well-being, our residents are often brought to the lounge and left with the TV on but minimal engagement. This is neglect and encourages loneliness and low self-esteem. Also, residents who remain in their room need mental stimulation and company. Engagement is to be recorded on the [computerised care planning system]. Staff observed chatting in the corridor or sitting on the steps having 'finished everything' instead of being with residents will be invited to a performance meeting.

The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The manager and staff gave examples of how they had supported people with communication. For example, they had contacted a specialist in learning disability for advice about communication. They had recognised that one person was able to communicate better at different times of day using information that was written down, or pictures. In addition, the manager was looking to develop pictures of food choices and pictures of activities to help people choose. Although the service had a specific policy in place there was a lack of consistency in care plans to guide staff. Some care plans contained detailed information about people's communication needs, while others contained none. For example, one person's records indicated

they were profoundly hearing impaired and had lost their hearing aids. A referral had been made to the audiology department, but there was no information in the care plan to alert staff or support communication. The manager advised they would make the necessary improvements to ensure compliance with the Standard.

Since the last inspection the service had developed a greater focus on supporting people at the end of their lives. People were often discharged to Langford Park from hospital at short notice. The service worked closely with health and social care professionals to ensure people's needs and preferences were understood and met, and their families were supported. Within the first 24 hours following admission, the service aimed to complete all the basic risk assessments, including falls, nutrition, and pressure area care. Within the first three days all of the risk assessments and care plans should be in place, including end of life wishes and preferences. The changes in management and staffing meant this hadn't always been achieved within these time frames, but the manager was confident that with two new skilled and experienced nurses in post this would improve.

Care plans contained information about people's mental, physical and emotional health, as well as their support needs and daily routines. There was also detailed information about people's background, cultural needs and preferences, which enabled staff to provide care in a personalised way. For example, one person's care plan stated, "I enjoy my own company most of the time and don't tend to feel lonely". The aim of the care plan was for the person to have their right to privacy respected while ensuring they did not become isolated. The care plan guided staff to, "Check on [...] on a regular basis throughout the day and assess their emotional and mental wellbeing. To do this staff should spend a few minutes chatting with [...] and should try and gauge if they are happy chatting or would prefer peace and quiet."

The manager told us the staffing and management changes meant care plans had not been reviewed in line with policy, although this would improve now that staff were in post. They were clear there had been no impact on people because staff had a good knowledge of people's needs and information about any changes had been shared. This was confirmed by positive feedback we received from visiting health professionals about the responsiveness of the support provided.

The provider had a complaints procedure which was displayed in the home. People knew how to make a complaint and told us they had confidence in the complaints process. One person said, "If I had any concerns or complaints I would speak to the manager. I feel comfortable talking to them". The provider was working to address some complaints and concerns raised by family members. Meetings had been minuted and copies shared with the families who indicated they were satisfied with progress being made. The provider told us, "We have met with the families and listened. We will meet with them continuously until they are satisfied the issues have been addressed. We want to help to rebuild genuine relationships."

Is the service well-led?

Our findings

At our inspection in June 2018 the rating for this key question was rated Good. At this inspection we found areas of concern, which meant the rating was now Requires Improvement.

Changes to the management team and staffing had impacted significantly on the effectiveness of the staff team. Although these changes were intended to improve consistency, they had undermined the existing structures and compromised the quality and safety of the service. One relative told us, "They are not so observant or attentive to the needs of patients."

The provider and management team were open and transparent throughout the inspection and committed to making the improvements required. The provider said "I have taken all my good members of staff and given them the opportunity to progress. The registered manager is now the operations director and the deputy is now the manager. This means I have taken out the cogs of a well-oiled machine and they now need more support. We did it all at once. We always agreed as a management team that we would test it to see if it works. We now need to put some of the cogs back into position."

The changes to the management team and staffing meant there was a lack of clarity about roles and responsibilities. This had caused some confusion for staff about who they were accountable to and what was expected of them. This issue had been addressed at a series of meetings for the different staff groups where roles and responsibilities were clarified. In addition, management training was being put in place for senior staff to improve their leadership skills. The provider and operations manager were very proactive and involved with the service in this period of transition. The manager was now supported by two deputy managers, including one with clinical lead responsibility. Two new nurses had been recruited. The nursing team now comprised of a senior nurse and three nurses, two of whom were specialists in mental health. There was a senior team leader and six senior carers, with one senior administering medicines, one running the shift and another on the night shift. In addition, there was a supernumerary senior carer to support new staff. The manager said, "This is working well. We are developing a proper day and night service." They told us, when the new staff have embedded there will be a clear system for monitoring and accountability".

People did not always live in a service which was effectively assessed and monitored to help ensure its ongoing quality and safety. Whilst, there was a system of quality audits completed every six weeks by the provider and operations manager, as well as daily medicines audits completed by the manager on the computerised planning system. The audits had not identified all of the issues we found during the inspection. This meant that since our inspection in January 2018, the provider's overall governance framework had not been suitably adapted and was still not effective in helping to drive and sustain improvement at the service.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities 2014).

We did however, positively recognise that action was being taken to address the concerns, related to induction and training, recording, medicines administration, staff competence and activities. The deputy

manager told us, "I think it's a safe service. The risks are managed and there is an action plan in place about how to manage them."

People living at Langford Park, their family, friends, and health care professionals were invited to express their views of the service through satisfaction surveys and interviews. There were occasional meetings for relatives. The activities co-ordinator told us meetings for people living at Langford Park were no longer being held, so they asked people for their views individually instead.

The home was managed by a person who had previously been the deputy manager at the service. They were in the process of registering with the CQC to be registered manager. The manager had extremely detailed knowledge of all the people living at Langford Park, including the support they needed and how they wanted this support to be provided. People at the service spoke highly of them. Comments included, "I love [the manager] – we get on ever so well", "I see the manager two or three times a week. They call in and chat" and, "The manager is very nice. They come and have a chat. You can talk to them any time". The manager operated an open-door policy, which was evident during the inspection when people living at the service came in to the office to ask for assistance. Even though there was an inspection in progress, the manager gave the person time, listened respectfully, and explained what they were doing to solve the issue.

Staff told us they were well supported by the management team and this helped them to do their jobs effectively. Comments included, "I feel supported by the structure. The management are approachable. That's a real strength as they are willing to help you out and explain", "The manager is great. The door is always open" and, "Even if it's a Sunday and there is only one nurse on, the management team are available. You can phone any of them and would get the support." Staff said they felt part of a team at Langford park, describing it as "one of the best homes I've worked in" which had a "nice feeling about the place." They felt able to put forward their ideas and contribute to the development of the service. One member of staff told us, "We talk about how we can improve things and better the care. If there is a new member of staff we can make sure they understand."

The company had developed a values framework based on respect for all, trust, professionalism, genuine relationships and excellent leadership, and was working to ensure these values were embedded across the service. The provider was committed to consulting with people, their relatives and other stakeholders to give them a voice in the way the service was being developed. They told us, "We are working to provide good governance at every level. We are building an effective board to take the business forward. The board members will include a resident, a resident's family member and a member of staff. We listen to people who work in the service or interact with the service to help shape the business going forward. We want to deliver outstanding care and make it a wonderful place to work." There was a focus on ensuring effective leadership. Individual personal development plans were in place for the management team, who, along with the provider were developing their leadership skills with the support of an external consultant.

The provider and manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. The manager and provider had acknowledged the areas in which the service needed to develop and improve, and been proactive in making this happen.

The manager was meeting their legal obligations such as submitting statutory notifications when certain events, such as a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested. The provider had displayed the previous CQC inspection rating in the main entrance of the home and on the provider's website.

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 9 HSCA RA Regulations 2014 Person-centred care
Diagnostic and screening procedures	Service users did not always receive personalised care that was responsive to their needs, particularly in relation to activities and stimulation
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	Service users medicines were not always managed safely.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	Service users did not always live in a service which was effectively assessed and monitored to help ensure its ongoing quality and safety.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Diagnostic and screening procedures	Improvements were required to ensure new staff had the skills, knowledge and experience to deliver effective care and support.
Treatment of disease, disorder or injury	