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Langdale Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 15 March 2016 and was unannounced. At the last inspection on 8 May 2014 the provider had met all the necessary requirements of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

At this inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to the control of infection and cross contamination. The provider was not meeting these requirements due to the unclean condition of communal bathrooms and toilets and people were not protected from unsafe practices around the control of infection. Efficient cleaning regimes were not taking place in the communal toileting and bathing areas of the home.

A registered manager was not in post, as the previous registered manager had left the service. The operations manager informed us they were in the process of recruiting to the registered manager position. In the interim the operations manager was covering all the management responsibilities in the home and also held a CQC registration for another location. Following the inspection the operations manager applied to become registered with CQC to be registered manager at this location. 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.

Langdale Lodge has accommodation for 27 people; on the day of our inspection 24 people were living there.

People were protected from bullying and harassment by staff who could identify abuse and who knew what to do in a situation where they witnessed it. Peoples' freedom was protected and there were sufficient numbers of staff on duty to meet their needs. Safe recruitment processes were in place to help to protect those living in the home.

Staff had the knowledge and skills they required to carry out their roles and responsibilities. They received the support they required with regard to induction, training and supervision sessions. Staff also felt comfortable to ask for any advice and guidance if they had any queries.

Medicines were managed in a safe way and people received medicines when they required them.

Staff received training related to the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) to make sure they knew how to protect people's rights.

People's nutritional needs were assessed and records kept to ensure people were protected from risks associated with eating and drinking. Where risks to people had been identified these were monitored and referrals made to relevant professionals.

Positive caring relationships had been developed between people and the staff who cared for them and people were supported to express their views. They were actively involved in making decisions about the care and treatment they received. People received care that responded to their wishes and needs and their views were respected and followed. People were supported to make choices about their lives. People were aware who to go to if they had any concerns or complaints and they were confident these would be acted upon.

Quality audits were undertaken to ensure quality of care was monitored, however the quality checks for cleanliness in the bathroom and toilet areas of the home had failed to identify the lack of cleanliness.

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 consistently safe.

People were not protected from risks relating to unsafe practices in cleanliness and infection control.

People were protected by safe recruitment processes which helped to ensure their safety. There was sufficient staff on duty to meet people's needs. Staff could identify signs of abuse and knew what to do if they witnessed this.

Medicines were stored and administered safely and accurate records were maintained.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the appropriate training and knowledge to work with people in an effective way.

Staff received training in relation to the Mental Capacity Act (MCA) and had an understanding of the Deprivation of Liberty Safeguards (DoLS).

People were supported to access external health care services when this was required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity and respect was not promoted at meal times.

We saw kind and caring interactions between people who lived in the home and staff.

People were involved in making decisions about their care and people told us they felt listened to.

Is the service responsive?

Good

The service was Responsive.

Staff had a good understanding of people's support needs and how they liked to receive their care.

People's views and preferences were sought with regard to how they liked to live their lives.

A complaints procedure was in place and people told us they felt able to raise any issues or concerns. They were also confident they would be listened to and any issues raised would be taken seriously and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was no registered manager in place and this was being addressed.

Quality monitoring systems failed to identify the unsafe practices around cleanliness and infection control.

Staff were aware of their responsibilities and knew how to treat people in a person centred way.

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Detailed findings

Background to this inspection

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

The inspection took place on 15 March 2016 and was unannounced. The inspection team consisted of two inspectors.

We looked at information we held about the service, this included notifications sent to us by the provider. A notification is information about important events which the provider is required to tell us about by law. As part of the inspection process we also requested information from the local authority contracts department and Healthwatch.

During the inspection we undertook a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with three people who used the service, one relative, the providers, the operations manager, one team leader, the chef, one carer and a domestic worker. We also spoke with a visiting health professional. Throughout the day we observed care practise and the administration of medicines as well as general interactions between the people and staff.

We looked at documentation, including four people's care records and handover information. We also looked at staff rotas, training rotas and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

The provider's arrangements for the prevention and control of infections, including the cleanliness and hygiene of the premises, did not fully protect people from the risk of unsafe care.

In one bathroom there was a malodour coming from the shower trap which had black mould around it. When we lifted the shower trap/plug hole there was odorous debris inside. In the same bathroom we saw dried faeces on the toilet raiser and the edges of the floor were unclean. The flooring was not sealed properly around the bottom of the toilet basin. This meant it would have been impossible to ensure it was hygienic.

In another bathroom we saw a dirty commode pan on the floor and there was a clinical waste bin stored on a rotunda. (A rotunda goes into people's rooms and is used for assisting with moving and handling.) This meant there was an increased risk of transferring infection and contamination across areas around the home and between people.

In a communal toilet we saw a dirty urine bottle and faeces on the porcelain toilet bowl. In another communal toilet there was a used urinal bottle on the window ledge. The toilets for use by people who lived in the home did not always contain soap and paper towels and we saw toilet roll holders hanging off the wall in some bathrooms and toilets. This lack of attention to basic hygiene needs put people at risk from cross contamination. The pedal bin in one of the upstairs bathrooms was broken where the foot pedal didn't work, this meant that people had to use their hands to raise the lid which was unhygienic and could have caused cross infection.

The laundry room had clean clothes hanging near dirty laundry; the mop for washing the floor was behind, and underneath, dirty laundry bags. This, again, could have caused cross contamination of germs and infection. There was no soap or paper towels for hand washing in the laundry.

In an empty room the bedding had not been changed since the person had left and there was a dirty pillowcase. There was also a split in the airflow mattress. The toilet seat in the en suite was dirty and damaged. We visited another empty room and found the toilet splattered with dried faeces. In a third empty room, where the person had been admitted to hospital, the sheets were stained with body fluids.

The sluice room had a strong odour of urine and contained dirty laundry. There was a dirty toilet brush and the corner of the room was dirty with debris. There was no soap in the sluice for hand washing and there was faeces on the door jamb. Edges of the cabinets were broken and held black dust which meant this area could not be cleaned properly. The sink area, where we were told was used to wash commode pans and urinals, was dirty and appeared to have not been cleaned recently. The floor was dusty and covered with debris. There was a separate wash hand basin but it was inaccessible due to equipment being stored in the room.

We found the premises and equipment were not always clean and hygienic and the provider's arrangements

for the prevention and control of infection did not fully protect people from the risk of infection.

This was a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulation 2014.

We saw evidence provided by the operations manager that showed when people are transferred from Langdale Lodge to other locations, for example hospital, the service user transfer form contained information about whether the person was carrying infection that me a risk to others.

We discussed our findings with the Operations Manager who accompanied us on our visit around the home and they agreed improvements were needed. The operations manager instructed staff to clean some of these areas while we were there.

All of the people we spoke with said they received the care they needed and felt safe in the home. One person said "Yes, I feel safe". A relative told us they were "Quite happy" with the care and support their [relative] received in the home. When we spoke with staff they told us they knew what to do if they witnessed, or suspected, the abuse of a person living in the home. They also told us they were confident they knew how to raise any concerns about people's safety and understood the procedures to follow if this occurred. One member of staff told us if they thought people weren't safe they would "Go to the manager".

Staff described the arrangements for their recruitment and employment to check they were suitable to work with people who lived in the home and we saw these had been followed. The operations manager described to us their recruitment policies and the checks undertaken before people were employed by the service. We could see these had been followed. This helped to protect people from harm and abuse.

All of the people we spoke with said they were confident they knew how to raise any concerns about the safety of people who lived in the home. Risks to people from their health conditions were assessed and people and their relatives told us they believed the staff knew how to support their family members safely. We saw that care records showed that, where people were at risk from skin breakdown, they were supported to relieve their pressure areas regularly by turning. There were handover sessions between staff when there was a shift change. These happened twice a day and helped to ensure the changing needs of people living in Langdale Lodge were addressed by staff who had just come on duty.

However, we found the information being recorded did not always contain a detailed description of any skin breakdown so that any improvements or deteriorations could easily be identified. The recording of skin condition was not always followed through in each day's written records. This meant there was no systematic process for ensuring people's skin was well maintained.

Medicines were administered effectively and safely. The medicines trolley was well ordered and any medicines opened had the date they had been opened recorded on the side of the bottle. All medicines were in date. Medicines were stored within locked cupboards within a locked room and the storage area was well organised. We checked the amount of medicines in stock and these tallied with those recorded. Medication administration records (MAR) charts were completed and up to date. Medications audits had been undertaken each month and these audits identified areas that required improvement. The records showed these had been acted upon. We saw from the training matrix that medicines administration training was up to date. This helped to ensure the safe use of medicines in the home.

A 'homely' remedies policy was in place. This had been signed by a GP and the local pharmacist and a list of approved homely medicines was available. By introducing homeopathic medicine the providers were helping to ensure a rounded approach to care.

The provider informed us that a fire risk assessment was carried out in January 2016 by the Fire Brigade and all recommendations were completed and up to date. However, the up to date certificate was not available to view.

A process for returned medicines was in place and they were all logged in a record book. However this was not always signed by two members of staff and the pharmacy delivery driver who collected the returns box did not always sign to confirm collection. The temperature of the medicines fridge was checked on a daily basis; however, there was no information about what was a normal temperature range for either the fridge of the medicines room. Lack of accurate recording in these two areas put people at risk from unsafe practice.

We saw there were sufficient staff on duty to meet people's needs. The Operations manager told us the total amount of staff hours were allocated to operate the service were based on the levels of need of people living in the home. However, we did see one person waiting twenty five minutes to be assisted to the toilet following their request. Also, one member of staff told us it was sometimes difficult to find a member of staff to help when it required two people to assist someone with moving and handling.

Good

Is the service effective?

Our findings

People told us they believed they received the care they required. They told us they were confident staff would listen to them and get help. One family member told us they were happy with the care their relative received and they were very happy with the way their [relative] was looked after.

Staff told us they were interviewed before they began work at the home and their induction consisted of shadowing a more experienced member of staff before they worked unsupervised. One member of staff told us they did not work independently with people until they were confident about working alone. They said senior staff respected when they told them they were not yet confident to undertake care alone and gave them the extra time they needed shadowing other staff members. New staff were also shown how to do things like completing people's records without delay and how to attend to people's individual needs.

Staff explained they had received various training while working in the home including safeguarding, moving and handling, nutrition and hydration. We saw from records that training in infection prevention and control had been undertaken by staff and that staff supervisions covered things such as safe handling and disposal of sharps, step by step handwashing and infection control. We saw from raining records training was up to date. One member of staff told us they had one to one meetings every two months with their line manager and we saw from records this was the case. Staff told us this gave them the opportunity to raise any matters about learning and safe practice and that they felt listened to. Performance appraisals were undertaken after two months with all new members of staff. This was to ensure they had the right skills and qualities to work with people.

Staff showed a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. 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 the mental capacity to make a particular decision, 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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and DoLS and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that appropriate procedures had been followed.

People told us they enjoyed the food, one person said, "The food is nice", and another person told us the food was, "Good". When we saw people eating their meals at lunch time we could see they appeared to be enjoying the food. Fresh ingredients and a variety of foods were available and used in the preparation of meals. There was a three week rotation of menus to ensure people were offered a varied diet and this was changed every three months to account for people's preferences. People were offered a choice of main meal each day. We spoke with the chef who told us they learned what food people liked and what they didn't like

and then adapted the menu accordingly.

We saw from care records people's dietary needs had been assessed and, where necessary, people were weighed regularly so their weight could be monitored. This gave staff information about when to contact health professionals if this was necessary.

One person told us "If I was poorly I would tell whoever was about" and they went on to say if they felt unwell they sure they would get the help they required. Staff told us it was easy to get access to local GP's and other areas of health care, for example, speech and language therapists. We saw from records that health care had been sought for people when it had been required. The operations manager explained that every two weeks there was a surgery in the home when the GP attended. This meant people's health was monitored by the GP on a regular basis.

Requires Improvement

Is the service caring?

Our findings

During the lunch time meal we saw there was little interaction between people and carers. In the main dining room aprons were put onto people without any explanation as to what they were for. However, when someone was being served their meal in a separate area we did see the member of staff explaining what the blue apron was for. We also saw that all people were given a blue apron, whether they needed it or not. It took fifteen minutes for everyone who wanted to eat their meals in the dining room to be there. This meant some people had been waiting at an empty table for fifteen minutes. People were then offered drinks but it was thirty minutes following the first person sitting at the dining table before food was served.

There was no explanation from staff about what food was being put in front of people and they were not offered any choices at the dinner table. One staff member was assisting a person with their meal but there was no interaction or explanation about what they were eating. We saw that plates were scraped onto a tray in the dining room in front of people who were still eating and, in one case; a dessert was left on the table before a person had finished their main meal. One person was given a dessert and asked what it was but no-one told them. Our observations showed that lunch time was organised and functioned for, the convenience of staff and not for the enjoyment or benefit of people living in the home.

People and their relatives told us staff were caring and felt they had good relationships with them. One person said the carers were, "Good", and another person said the staff were, "Alright". A third person told us they were, "Quite happy", with the carers and said, "I haven't found a member of staff that's not caring". One relative told us they felt involved in the care of their family member and had been asked when they entered the home what their likes and dislikes were and also about how they liked to receive their care.

We saw staff were mostly kind and caring and they told us they took time to get to know people when they first came to live in the home. They told us they learnt how people liked to receive their care by talking to them and their relatives and looking at their care plans. Staff told us they supported people to express their views and people could say what they wanted. One example of this was one person who told us they were supported to go to bed and get up in the morning when they wanted. Staff told us they always asked people how they wanted to be addressed and took the time to learn what they wanted. This communication between staff and people who lived at the home helped to create a caring atmosphere.

One member of staff told us they really enjoyed working at the home and, "It's like having a second family". They told us they enjoyed doing different tasks with people, always ensuring they were receiving the care they wanted in the way they wanted it.

Staff knew the people who lived at the home well and one member of staff told us they knew how one particular person behaved when they were sad. They went on to explain how they spoke with them to try and prevent them from being so sad. Another member of staff explained how there was one person who liked to talk a lot and how they tried to spend time with them so they could do this. A third member of staff explained how they tried to put themselves in the place of the person they were caring for so they could imagine what it was like. By putting themselves in the place of the people they cared for staff were showing

compassion.

Staff explained how they respected people's dignity when they were providing personal care. They took people to a private place and ensured curtains were closed and the door shut. They then talked to people to ask how they wanted their personal care to be delivered. We saw one member of staff assisting someone to move their position and they explained what they were helping with throughout.

Good

Is the service responsive?

Our findings

People told us they felt listened to and staff knew them well. We could see from the interactions between staff and people who lived in the home they were familiar with people's needs. One relative told us the staff would, "Always sort things out", if they raised any concerns with them. Staff told us if they noticed any changes in the needs of people they would record these in the care records so the information was shared across the care staff.

People's care records were personalised to reflect their identified wishes, preferences and goals and what was important to them. They contained details of people's personal life history, interests and information about how people wanted their care and support to be provided. We saw relatives had contributed to the completion of people's care records with information about their likes, dislikes and past history. One member of staff told us they were, "Always looking for changing and evolving needs", and, "Looking at all aspects of who they [people] are". For example, one member of staff explained to us about, "Positive risk taking", which meant risks to people were discussed with them but they were still supported to make their own informed choices. This helped to ensure people's support needs, including their likes and dislikes, were met. However people and staff told us they would like to be able to spend more one to one time together as this was what they [people] enjoyed.

There was an activities co-ordinator employed by the home and activities were undertaken in the home. Activities outside of the home had been undertaken recently, these included visits to a football match and a visit to Crufts by special request of people living at the home. By undertaking these trips people were experiencing social activities outside of the home.

People and their relatives told us they were satisfied with the home. They were aware of the complaints procedure and knew how to make a complaint if they wanted to. They also told us they were confident any issues or concerns would be listened to and acted upon. Staff told us that, where necessary, they supported people to raise and discuss any concerns they might have and they were given a complaints form if they wanted to make a complaint. However, they told us they tried to, "Sort them out", before they became big problems. One member of staff told us, "Effective communication", was important in maintaining a home where people were happy and concerns could be dealt with efficiently. Staff told us that complaints to the service were shared amongst staff so there was shared learning.

Requires Improvement

Is the service well-led?

Our findings

We found the checks of quality and cleanliness in the home were not always effective. They did not identify arrangements for the prevention and control of infection, including cleanliness and hygiene. They had not protected people from the risks associated with cross contamination and infection control. Audits were undertaken monthly and these were discussed on a regular basis with the provider. However, they had not been effective in ensuring the cleanliness of the home was maintained.

There was no registered manager for this location although the operations manager was covering their responsibilities and holds a CQC registration for another location. We were informed the recruitment for a registered manager was underway and, following the inspection, the operations manager told us they had applied to be registered manager in the interim. The operations manager was also covering four other services.

People and their relatives spoke positively about the management of the home and how it was run and said the all the staff were 'Good'. They confirmed they were asked for their views about the service and said they felt they were given information when they asked for it.

Staff we spoke with were aware of their responsibilities and valued the induction, training and supervision they received. Nursing staff were visible around the home and available for advice. Staff told us they enjoyed working in the home and one member of staff said, "I love being here, when I get here I'm happy", they also told us they, "Loved the atmosphere". The operations manager told us funding was available for improvements in the home if this was requested by them.

Staff told us they could talk to anyone about anything, including the managers in the home and the providers. One member of staff told us they felt there was a very, "Open culture", in the home and the management were, "Open and welcoming", to them. We spoke with the operations manager and they told us they wanted to raise the morale of staff as, "When they feel heard, and see what they say has a positive impact, I see them blossom" this was a reflection of their view about how they supported staff. By motivating staff management were helping to ensure an inspiring atmosphere in the home. One member of staff told us management were, "Amazing", with the people who lived in the home and did not spend all day in the office but spent significant time around the care home talking to people.

The management team consisted of operations manager, deputy manager, clinical lead nurse and head of care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Unsafe practices around cleanliness and hygiene control in bathrooms and toilets. Unclean linen on some beds and storage of mops in conditions which created a hygiene risk.