Langford Park Ltd

Langford Park

Inspection report

Langford Road
Langford
Exeter
Devon
EX5 5AG

Tel: 01392690116
Website: www.langfordpark.co.uk

Date of inspection visit:
07 January 2019
08 January 2019

Date of publication:
10 February 2020

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

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 35 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 January 2018 and found that improvements had been made, therefore the service was rated Good. However, at our inspection in August 2018 we found that the improvements had not been sustained and the service was again rated Requires Improvement overall. Aspects of the management and recording of people's medicines required improvement. People did not always have the opportunity to engage in activities and social stimulation, and were at risk of becoming isolated and depressed as a consequence. Significant changes in the management structure and staff team had undermined the quality and safety of the service. New staff had not received the induction, training and supervision required to do their roles safely and there were concerns about poor recording, decreasing standards of personal care and housekeeping, and a lack of clarity around roles and responsibilities. We found breaches of the regulations related to person centred care; safe care and treatment; staffing and governance and served a requirement notice.

Following the inspection further concerns about the safety of the service were raised. Langford Park became the subject of a whole home multiagency safeguarding investigation in December 2018. Whole service investigations are held where there are indications that care and safety failings may have caused or are likely to cause significant harm to people. These concerns meant the local authority, with the agreement of the provider, placed a suspension on any further local authority placements at Langford Park. The provider also voluntarily agreed not to admit privately funded people to the home during this period. Improvements to the safety and quality of the service meant the whole home safeguarding process was concluded on 26 February 2019 and the placement suspension lifted. The service continues to be monitored and supported through the local authority 'Provider Quality Support Process.'

Before the inspection we received concerns about the management and governance of the service. We carried out an unannounced focussed inspection of this service on 7 and 8 January 2019 to look into those concerns. We did not look at all the previous breaches and will report on those at the next comprehensive inspection.

While there had been some improvements, several issues identified at the inspection in August 2018, and in an audit completed by the provider in October 2018, had still not been addressed in January 2019. This included recording, risk assessing and training, for example in manual handling. The provider's failure to

address these concerns meant people had experienced harm, such as pressure area damage, and continued to be at risk of harm.

This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Langford Park on our website at www.cqc.org.uk can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Langford Park on our website at www.cqc.org.uk.

There was no registered manager at the service as the previous manager had resigned since the last inspection. 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. The providers operations manager was the acting manager pending the recruitment of a new manager.

At the inspection in August 2018 we found that although the provider had a comprehensive governance framework in place, this had failed to ensure the quality and safety of the service. At this inspection carried out in January 2019 we found this was still the case. People living at Langford Park had not been asked for their views of the service so were unable to contribute to the provider's quality monitoring. Monthly audits, including medication, care plans, staffing, accidents and incidents and safeguarding had not been completed, although the provider was aware of this in October 2018. This meant people were at risk because the provider did not have a clear understanding of the issues compromising people's safety and had not taken action to address them.

Although many of the issues had been highlighted at the inspection in August 2018 and through their own auditing processes, the provider and operations manager told us they had not been aware of the extent of the difficulties at Langford Park until the previous manager had left. They said they had learnt from their mistakes and were committed to identifying and addressing all of the issues as a matter of urgency. This work had started before the end of the inspection and improvements were being made, with the support of the local authority. Quality Assurance processes were to be more robust and would involve people, relatives and staff. Work was planned to rebuild the confidence of staff and ensure they were valued and well supported. The recruitment of a new manager was in progress.

The service was not always safe. Although staff, including agency staff, told us they had a good understanding of people's needs, risk assessments and documentation did not consistently support staff to recognise the risks and keep people safe. Risk assessments had not always been completed or were inaccurate. They did not consistently contain the guidance staff needed to keep themselves and others safe. People were not always referred appropriately to external health professionals. Care plans and guidance provided by external health professionals was not always evident in people's records for staff to refer to. The monitoring of risks was not consistently documented, which meant it was not always possible to see whether people had received the support they needed to keep them safe. Information about safeguarding concerns was not consistently escalated, or action taken to keep people safe.

Action was being taken to address these concerns. A new handover system had been introduced a week earlier to ensure information about risks was shared effectively across the staff team. The operations manager had begun to review all the risk assessments and care plans to update them and ensure their accuracy before the end of the inspection. Action was also being taken to improve recording and documentation, and ensure staff had the training required to use the computerised care planning system effectively. Safeguarding processes were being improved.

People were at risk because staff did not have the skills, knowledge or support to care for people safely. New and agency staff told us they had not been given a formal induction when they came to work at the service. Training deemed mandatory by the provider had been completed by only 43 per cent of staff at the time of the inspection. Staff had still not received the support and supervision they needed to enable them to support people safely. This had impacted on the quality of the service and the safety of people living there. The provider and operations manager had begun to address these concerns through the development of a new induction process which all staff would complete. Staff had begun to complete their mandatory training on line and further practical training was planned. Supervision, including clinical supervision for the nurses was being organised.

People were at risk because they did not consistently receive the support they needed to eat and drink safely. Staff were not always following care plans, and were giving people food which put them at risk of choking. Where people were thought to have capacity to choose to eat food which put them at risk, there was no evidence that the risks had been discussed with them or their capacity assessed in this respect. Records did not show they had been re-referred to the SALT (speech and language therapy) team for advice and guidance. The operations manager acted immediately to address these concerns by referring people to the SALT team and ensuring staff had a clear understanding of how to support people safely with nutrition and hydration.

The electronic system for medicines administration was potentially unsafe due to problems with the computer network. This meant there was a high risk of medication errors. The provider had rectified this before the end of the inspection.

There was inadequate security at the premises which put people at risk because visitors could enter the building without being vetted. This was our experience on arrival at Langford Park. We immediately made the provider and manager aware of this security risk, and before the end of the inspection they had taken action to prevent recurrence.

Staffing rotas, and our observations on the day of the inspection, showed there were sufficient staff available to meet people's needs. However, the perception of many of the people we spoke to and staff was that there were not enough staff and people's needs were not always met in a timely manner, particularly at night. One person, who needed two members of staff to transfer, told us there were not always two staff available when needed, so they had to spend long periods of time in bed. The acting manager told us they would look into why people had the perception there were not enough staff when the rotas said otherwise.

Concerns were raised before the inspection that a lack of social stimulation was contributing to a deterioration in people's mental health. Since the last inspection there had been significant improvements in this respect with the appointment of an experienced activities co-ordinator and a deputy who provided social engagement for people seven days a week. The risk of depression and social isolation had therefore been minimised for some people, but the work was in its infancy and further work was needed to ensure consistency for everyone in the home.

Before the inspection concerns were raised about poor hygiene and infection prevention, however we found people were protected from the risk of infections by appropriate infection control practices.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this time frame. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We are taking further action against this provider and will report on this when it is completed. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

People did not always have effective risk assessments in place to keep them safe.

Systems, processes and practices did not consistently safeguard people from abuse.

People were at risk because staff did not always have the skills, knowledge or support to care for people safely.

People did not always receive the support they needed to eat and drink safely.

Medicines administration was not always safe.

The security of the building was not safe, but this was addressed during the inspection.

People felt staff were not always available to meet their needs in a timely way.

People's risk of depression and isolation was minimised by a developing activities programme.

People were protected by effective infection control practices.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance processes were not effective in ensuring the quality and safety of the service.

The provider did not always ensure issues identified were addressed to ensure people's safety.

The provider and operations manager had begun to take action to improve the quality and safety of the service, with the support of the local authority.

Langford Park

Detailed findings

Background to this inspection

This focussed inspection was prompted in part by information shared with CQC following the inspection in August 2018. This indicated potential concerns about the management of risk related to; information sharing and recording; staff skills and knowledge; a lack of support leading to a poor standard of care; nutrition and hydration; depression and isolation caused by a lack of activities; security of the premises; unsafe medicines management; infection control; staffing levels and deployment; and the management and governance of the service. This inspection examined those risks.

We undertook an unannounced focused inspection of Langford Park on 7 and 8 January 2019. We carried out this inspection to check the safety and management of the service, in light of the concerns raised. The team inspected the service against two of the five questions we ask about services: "Is the service safe?" and, "Is the service well led?" No additional risks, concerns or significant improvement was identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity, so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection

This inspection was carried out by two adult social care inspectors and a specialist advisor with expertise in dementia care. Prior to the inspection we reviewed information we held about the service, including notifications, previous inspection reports, safeguarding and quality assurance reports. A notification is information about specific events, which the service is required to send us by law.

We looked at a range of records related to the running of the service. These included staff rotas, training records, medicine records, meeting records and quality monitoring audits. We also looked at 12 care records for people living at Langford Park. We spoke with 12 people and five visitors to ask their views about the service, and observed people being supported with their meal over the lunch time period. We spoke with twelve staff. This included the provider, operations manager, lead nurse, activities staff, care staff and housekeeper. We also had feedback from three health and social care professionals involved with people at the service.

Inadequate

Is the service safe?

Our findings

At the inspection in August 2018 there were concerns about people's safety and we found a breach of the regulations related to safe care and treatment. The service was rated Requires Improvement in this domain.

Before the inspection we received concerns that the service was not safe because information about risks was not consistently recorded or shared across the staff team, and with other agencies; staff did not have the skills, knowledge or support to care for people safely; people's nutrition and hydration needs were not being safely met; medicines were not being managed safely; there was inadequate security at the premises which was putting people at risk; people were at risk because there were insufficient staff; a lack of social stimulation was contributing to a deterioration in people's mental health and infection prevention at the service was inadequate.

At this focused inspection we looked again at people's safety, concentrating on the areas in which new concerns had been raised. We will look at all the key lines of enquiry for this area at our next comprehensive inspection.

People were at risk from harm because records were not always completed and staff did not have the information they needed to support them safely and meet their needs. There were some good examples of risk assessments and documentation but this was not consistent. For example, one person had been at Langford Park for three weeks but did not yet have a full risk assessment and care plan in place. They had been assessed as being at high risk of skin breakdown, but records showed they had not been repositioned for long periods. The person had sustained pressure area damage.

Staff told us about people with behaviours that challenged, placing themselves and staff at risk by refusing medicines and support with personal care, and becoming aggressive. Risk assessments for these people were inaccurate, which meant there was no guidance for staff about how to work safely with them.

Risks to people had not consistently been escalated to external health professionals, for example when a person was refusing to take their medicines or was at risk of choking. When specialist health professionals had been consulted, it was not always evident their guidance had been followed. For example, one person's care records contained recommendations from the speech and language team to minimise the risk of them choking, but this information had not been added to their care plan.

Risks were not effectively monitored and documented. This meant potential deterioration may not be recognised and referrals made for specialist support where required. For example, there were large gaps in the completion of bowel charts for a person who had been assessed as being at significant risk of bowel impaction. People who had lost weight were not being weighed regularly.

People were at risk because information about safeguarding concerns was not consistently escalated, or action taken to keep people safe. For example, an agency member of staff had continued to work at Langford Park following a safeguarding incident, before the agency had been informed or action taken to

investigate the situation.

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

We raised these concerns with the provider and acting manager. They told us they had learnt from their mistakes and were making improvements to ensure information about risks was shared effectively. A new handover system had been introduced a week earlier, to inform and update staff about current risks to people. Staff described the new system as "thorough", "robust" and "brilliant". Immediately after the inspection the operations manager advised they were completing a review of all risk assessments and care plans to ensure the information in them was current and accurate, and gave staff the information they needed to provide safe care. These improvements will continue to be looked at as part of our ongoing review and inspection of the service. Action was being taken to improve safeguarding processes and communication with agencies. We checked staff knowledge and understanding of people's risks. They told us they knew people very well and had a clear understanding of the support they needed. An agency member of staff said, "I know all the residents. I learn about people from working with them and asking the other staff." A relative said "The care is excellent. l feel my husband is always treated with respect and empathy, his medical needs are met and he is in safe hands."

Before the inspection we received concerns that staff did not have the skills, knowledge or experience to meet people's needs safely. We checked this during the inspection. Nursing and agency staff told us they had not had a formal induction when they came to work at Langford Park. Nursing staff did not receive clinical supervision. Training records showed that training deemed mandatory by the provider had only been completed by 43 per cent of staff. 57 per cent of staff had completed training in manual handling. One member of staff told us, "The training is very poor. This has been voiced many times. Staff don't have manual handling training. It puts people at risk. Staff have been signed off as competent when they aren't." Four people at the service had sustained damage to their pressure areas, which staff felt was a consequence of poor moving and handling. A visiting health professional also expressed concern about the way staff moved people with complex needs, and how their lack of knowledge increased the risk of skin damage. In addition, some staff were not competent or confident with the computerised care planning system, which meant information was not always documented, or care plans updated.

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

We spoke to the acting manager about the skills of the staff enabling them to meet people's needs in a safe way. They acknowledged that improvements were required to the support of nursing staff. They were planning to organise individual and clinical supervision to support nursing staff in their professional development and to reflect on their practice. A more comprehensive induction system had been developed since the last inspection, and all staff at Langford Park were due to be re-inducted using this programme to ensure they had the knowledge and skills to support people safely. The agencies had been told that staff could not work at Langford Park until they had completed the induction for agency staff. Training had been arranged, with all staff due to complete practical training in manual handling, and the mandatory training which was available on-line. Additional training was being organised as a matter of urgency, with the local authority nurse education team

Before the inspection we received concerns that aspects of the administration and recording of medicines were unsafe and this was putting people at risk. We checked this during the inspection and found this was the case. People's bottled medication and topical medications had open dates written to ensure staff would

monitor if they were still within safe use by dates. However, this was not the case for one person we reviewed. There were gaps in recordings of fridge and room temperature, which meant the provider had no oversight of whether these medicines were stored safely.

Before the inspection we received concerns that the electronic system for medicines administration was unsafe and this was putting people at risk due to potential errors. We checked this during the inspection and found that while the system itself was safe, this was undermined by network problems because the computer used to administer medication on the middle floor did not always synchronize with the other computer on the ground floor. Staff said this was frustrating and one staff member said, "it bothers me, medication errors can occur". The computer went off line while we were shadowing a medication round, and the member of staff had to look for an area where they could get back online. On one occasion they forgot what they had read on the electronic MAR (medicines administration record) because the computer was not located on or next to the medication trolley. The likelihood of medication errors was high and we were concerned.

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

Medicines were stored securely, including topical creams and controlled drugs (CDs). CDs are regulated under the Misuse of Drugs Act 1971 and require specific management and storage. Medicines cabinets were locked and medicine trolleys were bolted to the wall when not in use. Medicines were stored at appropriate temperatures, in line with manufacturer's guidelines, which ensured they remained safe and effective to use. People received their medicines from staff who were trained to do so. The two staff members administering medications at lunchtime were friendly and patient and gave people the time they needed to take their medicines, as well as those people on complex medication such as peg medication management regimes. The medication electronic system showed people's medicines records, which included important information such as allergies and an up to date photograph of each person.

Before the inspection concerns were raised that people were at risk because they did not always receive the support they needed to eat and drink safely. We checked this during the inspection and found some people were at significant risk of choking. Their care records stated they required a 'fork mashable' diet, but they were being given food which was unsafe for them to eat, some of this alone in their rooms where they could not be monitored by staff. One person was said to have the capacity to make this decision, but there was no evidence that the risks had been discussed with them or their capacity assessed in this respect. Records did not show they had been re-referred to the SALT (speech and language therapy) team for advice and guidance. We shared this concern with the acting manager on the first day of the inspection, who raised it with staff. However, on the second day of the inspection records showed people had again been given food that put them at risk of choking. The manager told us this was due to the 'culture' of the home, and that staff had said, "It's because we've always done it like that."

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

The acting manager responded to our concerns about the risk of choking by referring people immediately to the SALT team for review where required. They also continued to reinforce staff understanding of choking risks at the daily handover. Other aspects of the support provided with nutrition and hydration were safe. For example, we spent time observing the lunchtime practices in the dining room and found there were enough staff available to ensure people were provided with the support they needed. We observed staff provided this support safely, and at a pace that suited the person and their needs. Records showed that

food and fluid charts were in place and being completed.

We discussed our concerns about medicines administration with the acting manager. They told us that medication administration had been checked on a daily basis by the previous manager, however there had not been a formal audit, so they were unclear whether there had been any medication errors. The network problem had been rectified by the provider before the end of the inspection and formal medication audits reinstated to identify risks and ensure action was taken to keep people safe.

Before the inspection a concern was raised that the systems in place to ensure the security of the premises were ineffective, and visitors were able to gain entry without being vetted. This presented risk to people living at the service. We were informed of two occasions when agency staff, who were not booked, had gone straight to work with people without being checked on arrival. We assessed the security of the premises during the inspection. On arrival we pressed the doorbell. The door was opened remotely for us and we entered the building. There were no staff present to check who we were or why we were there and we were free to walk around the building unchallenged.

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

We immediately made the provider and manager aware of the security risk where we were able to enter the building without any checks. Before the end of the inspection they had taken action to prevent recurrence. Staff had been informed of the risk and were no longer able to open the door remotely. People living at Langford Park had been advised not to let visitors in, but to inform a member of staff that there were visitors waiting outside. Signing in systems for staff had been improved and reinforced.

Before the inspection we received concerns that people were at risk due to insufficient staffing levels and a high staff turnover. On the day of the inspection we found staff were meeting people's needs in a timely manner, and spending time chatting with them. However, we had mixed views from people, relatives and staff. People commented, "When staff are rushed, I don't get the care I need, so I often refuse it", "Sometimes I have to wait too long to use the toilet at night" and, "I can't fault the staff, they are always there when I need them and they are caring". An agency member of staff said, "It's one of the best homes that I've been to because it's not chronically short staffed. People seem to enjoy one to one time, sitting and talking. There is enough time for that." However, permanent staff told us it could be challenging to provide this level of support consistently. Comments included, "Staffing has improved although there are some days we struggle to have enough to cover everything", "There aren't enough staff. It will be ok once we are back to full staff capacity" and, "We need more permanent staff. There aren't enough staff. even with agency staff."

We raised these concerns with the acting manager. They were surprised by this feedback, telling us there were adequate staff on duty to meet people's needs over a 24-hour period, and that any gaps were filled by regular agency staff who knew the home. This was evidenced by the staff rotas. They did spot checks occasionally to monitor the call bell answering times, but did not have a system which allowed them to fully monitor the call bell answering times at any time during the day or night. They told us they would look into why people had the perception there were not enough staff when the rotas said otherwise

Before the inspection we received concerns that people's mental health was deteriorating due to a lack of social stimulation. This issue had been identified at the inspection in August 2018. Since then a new, trained and experienced activities coordinator had been employed, along with a deputy. They were employed to arrange social engagement for people seven days a week, including some evenings. We observed six people engaged in art activities in the morning and eight people making cakes in the afternoon. People who were

cared for in bed, or who chose to stay in their room, received individual social engagement, playing dominoes, card games, having a hand massage or chatting, depending on the person's choices and needs. The risk of depression and social isolation had therefore been minimised for some people, but the work was in its infancy and further work was needed to ensure consistency for everyone in the home. The activities coordinator told us they had only been in post a short while, and were intending to have activity goals agreed and recorded for each person.

Before the inspection concerns were raised about poor hygiene and infection prevention, however we found people were protected from the risk of infections by appropriate infection control practices. 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. The home had an infection control policy. The essential training to be completed by all staff, included infection control. The new housekeeper had not completed the infection control training yet but had plans to complete it quickly. They had not seen the infection control policy but did have clear processes for cleaning the home and for the secure storage of COSHH items. They also knew the correct processes and temperatures to wash soiled laundry to prevent the spread of infection. We observed the home was clean throughout and smelt fresh. People told us they felt the home was clean and their laundry was taken care of well.

Inadequate

Is the service well-led?

Our findings

At the inspection in August 2018 there were concerns about the management of the service and we found a breach of the regulation related to governance. The service was rated Requires Improvement in this domain.

At this focused inspection we looked again at the management of the service, concentrating on the areas in which concerns were raised. We will look at all the key lines of enquiry for this area at our next comprehensive inspection.

Several issues identified at the inspection in August 2018 had still not been addressed in January 2019. New staff had still not routinely had an induction, or completed training, including manual handling. There were still concerns about recording and the ability of staff to use the computerised care planning system effectively. Further concerns had been identified by the provider in an audit in October 2018, which stated, "There is a lack of care planning and risk assessing. There are residents who have recently joined us with little or no risk assessments". This was still the case in January 2019. The provider's failure to address these concerns meant people had experienced harm, such as pressure area damage, and continued to be at risk of harm.

At the inspection in August 2018 we found that although the provider had a comprehensive governance framework in place, this had failed to ensure the quality and safety of the service. At this inspection carried out in January 2019 we found this was still the case. People living at Langford Park told us they were not asked for their views about the service or their care, which meant they were unable to contribute to the providers quality monitoring. Everyone we spoke with, including relatives, told us they had not been asked to complete any questionnaires about their views of the home and there had been no resident's / relatives' meetings for a long time. Comments included; "I never see management and I'm never asked what I think of the home, or even about my care", "We haven't had residents' meetings for years", and, "I see X (the provider) and we chat but they don't ask me what I think of my care or what I think of the home and they never come to my room". One relative told us, "We have to ask for meetings, they never ask us".

The provider and operations manager completed a general audit every six weeks. The last audit in October 2018 found that the previous manager had not completed the monthly management checklist, which included medication, care plans, staffing, accidents and incidents and safeguarding. These audits had still not been completed by the time we inspected in January 2019. This meant people were at risk because the provider did not have a clear understanding of their responsibilities and of the issues compromising people's safety, such as the security of the building or the fact that people were at risk of choking.

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

The previous manager and a deputy manager had resigned from the service since the last inspection, and the operations manager was covering while a new manager was being recruited. We shared our concerns about the management and governance of the service with the provider and operations manager. They told

us they had not realised the extent of the difficulties at level at Langford Park until they had come in to cover when the previous manager left. They had learnt from their mistakes and were committed to identifying and addressing all of the issues as a matter of urgency. The operations manager said, "I'm not leaving until I'm sure it's the right person [the new manager]. I'm going to be much more hands on at Langford Park." Quality Assurance processes were to be more robust, and the monthly management checklist redesigned in line with the CQC's key lines of enquiry. The operations manager would then check it was being completed monthly and was effective. Both the provider and operations manager planned to be more visible at the service, and make sure they spoke with staff as part of their audit process. An environmental audit would be completed weekly by the provider. A residents meeting was planned, with a coffee and cake evening for relatives, which would provide an opportunity to share views about the quality of the service. These suggested plans would benefit people and improve the quality and safety of the support provided. We will continue to monitor them as part of our on-going review and inspection of the service.

The operations manager told us, "I want to get it right for the residents. It bothers me that they are at risk. Staff need some support and structures need rebuilding. Staff do deliver good care, but the team needs to rebuild confidence. We need to let them know they are good enough." The majority of staff we spoke to had confidence in the operations manager. One member of staff said, "Staff morale is low due to the situation they've ended up in through no fault of their own. [Operations manager] will turn it around. They love this place. It's their baby. They were mortified when they found out what was going on. They are here all the time and don't miss anything."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 Regulation 12 (2)(a) The provider did not consistently assess the risks to the health and safety of service users. Regulation 12 (2)(b) The provider did not do all that is reasonably practicable to mitigate assessed risks. Regulation 12 (2)(c) The provider did not ensure that staff had the qualifications, competence, skills and experience to provide safe care. Regulation 12 (2)(g) The provider did not ensure the proper and safe management of medicines.

The enforcement action we took:

Impose positive condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (2)(a) The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service. Regulation 17 (2)(b) The provider did not consistently act to mitigate the risks related to the health and welfare of people. Regulation 17 (2)(e) The provider did not seek and act on feedback from people and their relatives for the purpose of evaluating and improving the service.

The enforcement action we took:

Imposing positive condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(2)(a) The provider did not ensure that staff received appropriate support, training, professional development and supervision as is necessary to enable them to carry out the duties they are employed to perform.

The enforcement action we took:

Impose positive condition.