J Sai Country Home Limited

The Langston

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on 13 February 2018. The Langston is a residential setting which means people receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The Langston is registered to provide support for up to 36 older people. On the day of our inspection there were 32 people using the service.

At the last inspection in December 2015 the service was rated Good in all domains and Good overall.

At this inspection we found the service remained Good.

The service was well run by the new manager who was supported by a team of nurses, care staff and support staff. The manager who had taken over the service had applied to Care Quality Commission (CQC) to become the registered manager. A registered manager is a person who has registered with the CQC 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.

There was an open and transparent culture that valued people, their relatives and staff. The provider had systems to monitor the quality of the service provided and appropriate action was taken when required. The service worked well with various external professionals when required. People and relatives were positive about the new manager.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. People's rights to make their own decisions were respected. Staff were knowledgeable about MCA and knew how to adhere and act in practice. People's care plans outlined people's abilities in relation to their decision making and stressed the importance of respecting people's rights. We however found the records surrounding people's capacity needed to be clearer as these did not always reflect the specific decisions where people were deemed not to have capacity to make these decisions. We made a recommendation that the provider refers to the Code of Practice when formulating capacity assessments.

People remained safe at the service. Staff understood how to protect people's safety and how to raise any safeguarding concerns. Risks related to people's individual needs were identified and appropriate guidance was in place how to manage these risks. People were supported to access various external health professionals when needed and meet their nutritional needs.

There were enough staff to keep people safe. On the day of our inspection people were assisted promptly.

The provider followed safe recruitment procedures. Staff were skilled and had the relevant training and they told us they were well supported.

The service continued to provide care and support in a compassionate way. Staff respected people's privacy and treated people with dignity. People were involved in decisions about their care and their independence was promoted as much as possible. People's confidential information was respected. People's individual needs in relation to access to information were respected and we saw the provider used information in easy read, such as pictorial format when required.

People's needs were assessed prior to admission to The Langston. Individualised care plans ensured people's needs were respected. Staff knew people's needs well and knew how to support them effectively. People were provided with a choice of social activities, according to their needs and preferences.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains safe.	**Good**
Is the service effective? The service remains effective.	**Good**
Is the service caring? The service remains caring.	**Good**
Is the service responsive? The service remains responsive.	**Good**
Is the service well-led? The service remains well-led.	**Good**

The Langston

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 and to look at the overall quality of the service.

This inspection took place on 13 February 2018 and was unannounced. The inspection team consisted of two inspectors 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.

Before the inspection we reviewed the information we held about the service and the service provider. The registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law.

Throughout our inspection we spent time observing care at the service. We spoke to 10 people and five relatives. We also spoke with the manager, two nurses, one care coordinator, two care assistants, the maintenance man, the activity assistant and the chef.

We looked at records, which included four people's care records and the medication administration records (MAR) for three people. We checked recruitment, training and supervision records for four staff. We also looked at a range of records about how the service was managed. Following the inspection we contacted five of external health and social care professionals and commissioners to obtain their views about the service.

Good

Is the service safe?

Our findings

People and their relatives we spoke with told us people remained safe. One person said, "Yes very safe. It's the security, all the doors have locks and so do the windows". One relative said, "There is 24/7 care here and they are always checking on [person] every hour at night because she can't use her call bell".

People were protected from the risks of abuse and staff received training in safeguarding. Staff were confident any concerns raised with the management team would be addressed and they also knew how to report outside the organisation. One staff member said, "I'd go and report [any concerns] to the person in charge".

People received medicines as prescribed. Medicines, including medicines requiring additional controls because of their potential for abuse were stored safely and securely. The medicines room and refrigerator, temperature records provided assurance that medicines were stored within the recommended temperature range. Records relating to the administration of medicines were completed accurately. We observed a medicine round. Staff sought people's consent before administering the medicine and ensured they signed the records after the person had their medicines. One person said, "Yes, [staff give me medicines] for blood pressure and diabetes. And I get it on time and they always watch me take them".

People were protected from risks associated with their health conditions. Staff assessed any risks and care records included guidance how to reduce potential harm to individuals. For example, risks associated with falls, moving and handling, malnutrition and skin integrity. Risks to people's well-being were managed well. For example, one person was undergoing treatment for pressure area injury. The records showed staff had sought specialist advice and a tissue viability nurse had visited the person. Their wound care plan showed the details of the treatment this person required. We saw a recent care plan entry that read 'pressure ulcer getting better'. Staff told us this was confirmed and documented by photographic evidence.

The provider followed safe recruitment processes and there were enough staff to keep people safe. We observed people that chose to remain in their bedrooms had call bells within reach. Where people were not able to operate their call bells, they had regular safety checks. Comments from people and relatives included, "They [staff] do most everything you want straight away. Plus they've got full staffing" and "I use it [call bell] very rarely but when I do they come very quickly".

People were protected from risk of infections. Hand sanitiser gel was available. We saw staff used personal protective equipment (PPE), for example staff wore disposable plastic aprons when serving food. Gloves, aprons and wipes were available. One person said, "My room is always nice and clean, and they clean it every day".

People were protected from environmental risk, as there were systems in place to ensure various checks were completed. These included areas such as fire alarm, water temperatures, legionella testing and various equipment checks. We saw that people had personal emergency evacuation plans (PEEPs) for emergency use. These indicated the assistance required should an emergency occur, including a need for an

evacuation.. The provider had systems to record accidents and the records showed appropriate action had been taken where necessary.

The manager ensured they used reflection practices as a learning opportunity. For example, we saw from the meetings minutes that a press article about neglect in another care establishment was discussed and the team reflected on their own practices.

Good

Is the service effective?

Our findings

The service remained effective. People's rights to make own decisions were respected. People told us they were in charge of their care and their wishes were respected. One person said, "Yes, anything they [staff] do they always ask my permission". Another person said, "I am being well looked after, it would be nice to be home, but they look after me well".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff had a good knowledge of how to apply MCA in practice. One member of staff told us, "We should think that each and every person has capacity to make decisions unless proven otherwise". Another member of staff said, "Always assume people got capacity, unless proven otherwise".

People's care plans outlined people's abilities in relation to their decision making and stressed the importance of respecting people's rights. For example, one person's care plan read 'to encourage and assist [person] to make decisions for them where possible, minimising risk. Recognise that [person's] capacity may fluctuate'. We however found the records surrounding assessments of people's capacity did not reflect which specific decisions were being assessed. We raised this with the management who immediately redesigned the form used to record these and reassured us they would ensure all people's care records are reviewed and updated.

We made a recommendation that the provider refers to the Code of Practice when formulating decision specific capacity assessments.
People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The applications had been made to the local authority when people were being deprived of their liberty.

People's needs had been assessed before they came to live at The Langston. We saw where applicable people's care files contained copies of assessments obtained from commissioners. This information was used to create people's care plans to ensure people received effective care. The manager ensured people's needs were met. They told us how they identified that one person would benefit from living in a different setting. The person had been admitted to the service from hospital when they were unwell and after a few weeks they started expressing a wish to live in another setting. The manager liaised with the social services to ensure appropriate arrangements for the transition were being made. It was clear the person's needs were central and the person was involved and listened to.

People praised the staff, their skills and told us how they received effective care. One person said, "Yes

everyone knows my name and they do build relationships with me, knowing what I want and my needs". One relative said, "[Person] is being looked after really well as he couldn't look after himself at home". Staff told us and records confirmed that staff received training relevant to their roles. One external professional told us, "The manager released all the staff to attend the seven hour training I offered. This is unusual in my experience".

Staff were well supported and told us they did not need to wait to their scheduled supervision; and were able to get support any time. One staff member told us, "I had supervision every two to three months with the deputy manager". Another staff told us they had regular supervision. They said, "For the whole year it must be four times".

People were supported to maintain good health and access external health services. A range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. We saw evidence that referrals to the mental health team, the dietician and Speech and Language Therapist (SALT) were made when needed. People told us they could see health professionals as needed. One person said, "I have seen the GP but not the optician or dentist but the chiropodist comes in here regularly".

People were supported to meet their nutritional needs and their care plans gave details of people's dietary preferences. People were complimentary about the food provided. Comments from people and relatives included, "The food is very good. I have pureed food and thickened drinks" and "It's good, plenty of it. And if it's not what you want they will make something else for you". We observed the meal service, which was a positive social event. When people required assistance, they were supported by staff in an appropriate manner. People that needed for example, a pureed diet received appropriate meals. Kitchen staff had sufficient information around people's nutritional needs including their preferences, choices, special diets and any allergies.

People benefitted from clean and spacious environment and choice of communal areas such as a dining room and a lounge. People were able to personalise their bedrooms with items important to them. The manager informed us a maintenance plan had been introduced that included redecoration and replacement of furniture and fittings. A recently added Orangery was going to be used to encourage smaller social gatherings.

Good

Is the service caring?

Our findings

The service remained caring. On the day of our inspection we observed there was a positive atmosphere and plenty of positive banter. Majority of the staff had been working at the service for a significant time and that contributed to the warm and caring atmosphere at The Langston. Staff were very friendly and made sure they introduced us to people. We observed the following sentence was displayed in the reception 'Our residents do not live in our workplace, we work in their home'. This was aimed to remind the staff that people were in the centre of service delivery.

People and their relatives complimented the caring nature of the team. One person said, "Oh yes it's like a family here". One relative told us, "On her birthday they put on a party for her with cake and finger food and they did it in her room and she loves her room". People were able to build meaningful, caring relationships with staff, which contributed to people's emotional well-being. We observed one of the staff members saying to the person that due to the fact they lived so far away from their family home they looked at the people here as their family. We saw the person was touched and became emotional. People's relatives could come and visit people at any time and with no restrictions. One person told us, "I have family members come and see me and they can come and go when they like".

People told us their dignity was maintained. One person told us, "They always knock and if their doing anything for me they always close the curtains and door". One relative told us, "When they changed [person's] dressing on her foot they pulled the screens round and if they are doing anything in the room and I knock on the door they won't let me in".

People's independence was promoted and people were encouraged to do as much for themselves as they could. One person told us, "I do try to do things by myself like walking with my walking frame". One member of staff told us, referring to process of medicines being given covertly (hidden in food) "I am trying first if [person] will take the medicines (non-covertly), it's the law". This meant staff ensured people were in control as much as possible and able to make decisions about support received.

People's individual needs including needs around diversity and equality were recognized and respected. The provider had policies in place surrounding equality, diversity and inclusion that stated the service's aim was to celebrate differences and stamp out any form of discriminatory behaviours. The provider adhered to equal opportunities when recruiting staff and there was a diverse team of staff from various ethnic backgrounds working at The Langston. The service collaborated closely with the local charity that worked with young people living with a learning disability and as a result of this a member of their learning programme was offered a job at the home. One external professional told us, "My impression was that they do respect people's differences. They are a diverse staff team".

People had access to information in a way that was accessible to them. For example, we saw that one of the recent quality surveys was in a pictorial form. The questionnaire used smiley, thinking or sad faces aimed to help people to express their views. Staff told us how they supported people with individual communication needs. One staff member said, "We used to have people when after they suffered a stroke and were unable

to communicate and we used pictures, cards. Some people use objects such as a cup, we know they would like a drink. The fact that we're a stable team means we get to know people's needs well". One external professional told us, "I worked together with the team to develop highly person-centred communication support around one individual and believe the staff developed their skills and put them into practice with this individual".

People's confidentiality was respected. People's care records were kept secure in the lockable cupboards. Staff had training around data protection and knew how keep information secure.

Good

Is the service responsive?

Our findings

The service continued to be responsive. Care records contained details of people's life histories, likes, dislikes and preferences and included care plans for aspects of daily living. People's care plans and risk assessments had been reviewed regularly and we saw evidence of relatives' involvement in care plans where applicable. Staff that supported people were aware of, and respected people's preferences and needs.

Where required people had specific care plans that met their individual needs, for example, a wound care plan. Staff also ensured the records of daily interventions were kept. We saw when required records of people's repositioning and food and fluid intake were in place. We also saw evidence that observations had been completed in relation to checks of the person's pressure areas and of their pressure relieving mattress as needed.

People told us they received support that met their needs. One relative also told us, "I wouldn't send [person] anywhere else. [Person] was here on respite but when they went into hospital they wanted to send them somewhere else, but I said – no [person] has to come back here so I spoke to the manager at the time and she was allowed back".

People had access to activities. There was an activity calendar in place that listed various activities that were on offer six days per week. On the day of our inspection we observed 'Golden Toes' the activity that included gentle chair exercises. The session was well attended and we observed numerous positive interactions between the staff and people. The session then turned into a chair dancing with the residents holding scarves. We also observed a member of staff reading out of book to all the residents, some other people enjoyed knitting and crosswords.

People and their relatives knew how to make a complaint and felt any concerns would be addressed. One person said, "I do think they are transparent in here, and very open, anything I ask is always answered very quickly. The one thing I like here is that anything I have to say is taken seriously". The provider had a complaints policy in place that was available to people. We viewed the complaints log and saw that four complaints have been received since our last inspection. These were investigated and where required action taken.,- For example, one complaint resulted in a recommendation that staff are reminded of a whistle blowing procedure. Staff we spoke with knew about the whistle blowing. They said, "Recently we've been reminded of whistle blowing [procedure]".

At the time of our inspection, no one was receiving end of life care. People's care records outlined people's end of life wishes. 'Do not attempt cardiopulmonary resuscitation' (DNACPR) orders were in place and these had been discussed with the person or relevant others, or both. The team would work closely with professionals, such as the community hospice team if required to ensure people had pain free and dignified death. The manager informed us that if a family wanted to stay overnight to remain with a poorly relative they would support them to do so. One nurse told us they had specialist training that included use of syringe drivers for medicines used in end of life care. The manager told us they planned to introduce two champions in end of life care soon and considered working towards the nationally recognized accreditation in end of

life care.

Good

Is the service well-led?

Our findings

The service remained well-led. There was a manager in post who had applied to Care Quality Commission (CQC) to be a registered manager. A registered manager is a person who has registered with the CQC 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 manager took over from the former registered manager that retired last autumn. We had positive feedback about the new manager. One relative said, "The new manager, we got on really well, and she is easy to talk to and very open and yes she is doing a good job". On the day of the inspection we saw the manager engaging well with people and working hands on wherever people needed to be supported.

There was a positive atmosphere at the service and this was apparent throughout all levels of the organisation. We were welcomed warmly by the staff who were keen to speak to us. They often referred to the service as 'a family' and it was clear they felt a sense of belonging, pride and wanted to achieve positive outcomes for people.

People and their relatives were involved in running of the service. There were regular opportunities to provide feedback such as meetings and surveys. The provider recently ordered some new armchairs and people were asked to pick their favourite colours of fabric. People told us they felt involved. One person said, "Yes, I have been sometimes to the meetings, and they do listen and act upon them". There was a 'you said; we did' board in the reception that reflected the action taken as a result of feedback received from people. For example, a new choice of meal options was discussed with the chef and introduced upon people's request.

Staff were also encouraged to attend staff meetings. We saw that various meetings had taken place , this included nurses meeting, head of departments meeting and carers meetings. Staff told us how they could contribute to the running of the home. They said ideas suggested by staff were considered and implemented when appropriate. One staff member told us, "We suggested that personal protective equipment (PPE) is now kept in bedrooms". Staff praised the support from the manager and director. A member of staff said, "She's good, she's actually new. You can approach her any time". Another staff said, "She is fantastic and really enthusiastic, I am very happy here. Director visits weekly, he always personally says thank you to everybody".

The manager ensured they developed their team; therefore a number of lead roles were introduced. These included nutrition, infection control, wheelchairs, mattresses, creams and falls. This gave staff opportunity to develop their areas of interest and act as a point of contact and a champion for their chosen area.

The provider had systems to monitor the quality of the service provided. The audits covered areas such as care plans, laundry, cleaning, accidents, activities and unannounced night visits. When an action was required that was followed up, for example, a care plan audit stated improvements needed and this information was passed on to the key nurses to follow up. The manager showed us how they improved the

audit template form so there was clear evidence the actions delegated to nurses were completed.