Mr Daljit Singh Gill

The Langleys

Inspection report

12 Stoke Green
Coventry
West Midlands
CV3 1AA

Tel: 02476636400

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 2 and 8 November 2016 and was unannounced. The Langleys is registered to provide personal care for up to 15 older people. At the time of our inspection there were 12 people living in the home.

During our last inspection on 6 October 2014, we found the provider was not fully meeting the standards required. This applied to the standards related to "Effective" and "Well Led". This meant we allocated an overall rating of "Requires Improvement". During this inspection we found that whilst some improvements had been made and overall people were happy with the service they received, some areas continued to need improvement and additional areas for improvement were also identified.

There was a registered manager in post who was registered with us in July 2015. This manager had previously worked in the home in the registered manager's position for several years but had left and returned. 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.

People told us they felt safe living at the home. The provider carried out a range of recruitment checks to ensure staff employed were safe and suitable to work with people. Risks associated with people's care had been identified but records and communication processes were not always clear to ensure staff knew how to respond to risks in order to maintain people's safety.

Medicines were stored securely but medicine records did not demonstrate people always received their medicines as prescribed. Audit processes had not been effective in identifying errors.

Care staff at The Langleys completed catering duties in addition to providing care to people. This impacted on their time and meant there were times of the day when staff were particularly busy. Despite this, people felt there were enough staff on duty to meet their care needs and there were enough staff to keep people safe. However, staff had limited time to support people's social care needs to provide person centred care. The atmosphere in the home was quiet with people relaxing either in the communal areas of the home or their rooms. During mealtimes people came together and there was social interaction between people and staff.

People felt staff had the skills and experience required to meet their needs. Staff completed training on an ongoing basis to help them develop their skills and competence to carry out their role safely and effectively. Staff understood their roles but were not always clear what was expected of them in regards to the completion of records. Staff were supported by the registered manager through one to one supervision meetings and staff meetings. People felt staff were caring and were positive in their comments of staff. Staff aimed to support people's privacy, dignity and independence but this did not always happen.

The registered manager and staff had some understanding of the Mental Capacity Act but the principles of the Act were not always followed. It was not possible to determine whether people had the capacity to make decisions that impacted on their care and people were not always involved in these decisions.

People said they had enough to eat and drink and there were meal choices provided each day. Where people were at risk of poor health, due to not eating or drinking enough, there were processes to monitor their food and how much their drank to help ensure their health was maintained.

Visitors were made to feel welcome at any time to help people to maintain relationships with people important to them. People felt at ease to raise any concerns with the registered manager. However, the complaint procedure had not been updated to ensure people had access to the information needed to escalate concerns further if needed.

Each person had a care plan which contained the information staff needed to meet people's care needs. Plans did not always contain person centred information to assist staff in ensuring people were supported in accordance with their wishes and preferences.

There were systems to monitor the quality of the service and drive improvement within the home. The provider was in regular contact with the home so they could monitor the quality of care and service provided. People and staff spoke positively about the home but quality monitoring did not always identify areas needing improvement.

People and staff were positive in their comments of the registered manager.

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.

There were sufficient numbers of staff to keep people safe but staff were not always clear on safeguarding and accident and incident procedures to ensure these were followed and people's safety maintained. There were some practices associated with medicines management that needed to be improved although overall people received medicines as prescribed. Staff were aware of risks associated with people's care and supported people to maintain their safety and wellbeing. Recruitment records showed safe processes had been followed so that staff were suitable to work with people who lived at the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff completed training on an ongoing basis to help ensure they had the right skills and knowledge to support people effectively. However, staff did not fully understand the principles of the Mental Capacity Act (2005) to ensure people, where appropriate, were involved and supported to make their own decisions. People were supported to attend appointments with external healthcare professionals to maintain their health and wellbeing. People's nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were supported by staff who they said were caring and kind in their approach. Overall, people's privacy and dignity was respected. People were supported to maintain relationships with those who were important to them and visitors were made to feel welcome.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive person centred care to ensure

their needs and preferences were met. Access to social activities in accordance with people's interests was limited. Staff responded to people's requests for support when needed. People knew who to approach with any complaints but the complaints procedure was in need of updating.

Is the service well-led?

Requires Improvement 

The service was not consistently well led.

People were mostly positive in their comments of the home but we found processes and systems were not fully effective in ensuring the quality of service was always maintained. Staff were positive about the registered manager and working at the home.

The Langleys

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.

This inspection took place on 2 and 8 November 2016 and was unannounced. The inspection was carried out by one inspector.

We reviewed the information we held about the service including the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority commissioning officer to find out their views of the service. The information they shared was similar to what we knew about the service. We looked at the last visit report completed by Healthwatch so that we could see if any of their recommendations had been considered or implemented. Healthwatch England is a national independent organisation and their sole purpose is to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.

Before the inspection, the 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. The information in the PIR gave us basic information about the home, which we reviewed during our inspection.

We spoke with five people who lived at the home, one visitor, two care staff, the registered manager and the provider. We observed the care provided to people and reviewed the care plans of two people in detail. We also reviewed other records to demonstrate the provider monitored the quality of service such as staff meeting minutes, staff training plans, quality monitoring questionnaires, audit checks, accident and incident records, health and safety and medicine records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at The Langleys because they had the privacy of their own rooms and staff knew about their needs and how to support them. One person told us, "Yes I feel very safe, the surroundings are homely and our little rooms are quite safe. We get no interference from anybody; we are all put to bed safely. I can't find any fault at all."

Staff were aware of their responsibilities to protect people from harm. They told us they had received training in protecting people from the risk of abuse and understood they needed to report any concerns to the registered manager. One staff member told us, "We check for marks and different behaviours and things key for abuse like withdrawal. When you work with the residents you get to know them better and the signs are clearer to you." However, staff were not aware of the safeguarding process to follow in the absence of the registered manager and were unsure of the processes for recording information in relation to any concerns identified. The registered manager acknowledged the need for staff to be provided with information about this.

The registered manager and senior staff understood their responsibilities to minimise any risks to people's health and safety. The Provider Information Return (PIR) forwarded to us prior to the inspection stated, "Risk assessments are carried out in the home and reviewed yearly or as changes occur." The registered manager told us they undertook assessments of people's care needs and identified any potential risks in relation to their needs before they came to live at The Langleys. This information was then transferred into care plans with instructions for staff to follow to help minimise these risks to keep people safe, for example, risks of falling.

When we asked staff how they kept people safe their responses demonstrated they knew what was expected of them to respond to risks. One staff member told us, "By checking everything in care plans, mobility, how they are eating and drinking. Having handovers (sharing information about people at the beginning of the shift), working as a team and regular contacts." We asked staff how they would know about any risks associated with people's skin such as red areas which could become sore or develop into pressure sores. One staff member told us, "That's a general thing you observe when you get them up (red areas). I would know by washing and dressing them. Hopefully it would be in the handover sheets and daily report sheets (information staff write about people each day)." They went on to tell us, "[Person] had a red area when I got them up, it was a rash and [registered manager] got some different cream for them through the doctor." This demonstrated staff knew about the importance of responding to risks so that advice and treatment could be sought to meet the person's needs.

Another staff member told us if they noticed a person had bruises they would "document" it and tell the registered manager so this could be followed up as necessary. They stated the information would be recorded in the daily notes they completed for the person and they would also complete a body map to show where the bruising was.

The registered manager told us she observed staff when they were working to make sure they carried out

their duties safely and in accordance with the provider's policies and procedures. They told us if staff were found to be carrying out unsafe practice, they were told immediately. For example, one staff member walked behind a person to make sure they did not fall but this resulted in the person leaning back towards the staff member when walking which was not safe. The registered manager advised the staff member how to support the person safety.

People felt there were enough staff on duty to meet their basic care needs and keep them safe. We saw there were periods of time during the day when staff were particularly busy such as mealtimes but despite this, staff ensured people were given their meals as quickly as possible.

The registered manager explained there had been some staff off sick, on holiday or maternity leave that had impacted on staffing arrangements. This had resulted in staff being sought from a staff agency. The registered manager told us they used the same agency staff so that people had continuity of care.

During discussions with the registered manager we established staffing levels were based on numbers of people in the home as opposed to assessing people's needs through the use of a dependency tool. A dependency tool is used to consider people's needs and the support they require to arrive at suitable staffing levels for the home. However, the registered manager told us that if people's health deteriorated she would not hesitate to bring in extra staff members to provide support.

The registered manager told us there were enough staff to support people. Care staff were rostered to complete other duties in the home such as cooking. There were three staff rostered to work during the day and two staff, according to duty rotas, to provide care. We saw two care staff were on duty. The registered manager was also available in the home in addition to these staff. The provider was in the home on the first day we visited to provide support to staff in the absence of the registered manager. At night there were two care staff on duty, one of these was awake and one sleeping in case they were needed to provide support. The registered manager told us she was always available for staff to contact in an emergency situation and was "on-call" during the night.

The provider's recruitment procedures ensured staff were safe to work with people. Staff told us they were not allowed to start work until their recruitment checks had been completed. The registered manager told us that new staff shadowed (worked alongside) more experienced staff to help them understand their role and responsibilities. Records showed that staff were recruited safely, which minimised risks to people's safety and welfare. The provider carried out police checks and obtained appropriate references to ensure staff were safe to work with people who lived in the home.

The PIR submitted to us by the provider stated, "Medication checks are carried out each day and audited once a month". We saw medicines were stored safely and securely and there were checks undertaken to ensure they were kept in accordance with manufacturer's instructions and remained effective. Only staff who had completed training in the safe management of medicines gave people their medicines to help ensure medicines were safely managed. There was a medicine administration folder with medicine records for each person which contained their photograph to reduce the chances of medicines being given to the wrong person. We found through checking the medicine administration records (MAR's) and carrying out medicine counts that there were discrepancies. For example, one person was required to take two different doses of the same medication on alternate days. We found that they had been given the same dose on two consecutive days in error. It was not evident this error had been identified or reported to the registered manager. We also found, when carrying out medicine counts of pain relief medicines, that there were two more tablets than there should have been when checking the MAR's. This suggested the tablets may not have been given when they should have been. The information recorded on the MAR's was not always

legible so that it was clear how the medicine had been managed, and to confirm people had received their medicines as required. This information was shared with the registered manager so that action could be taken to resolve this.

The provider had taken measures to minimise the impact of unexpected events such as fire risks. People had individual evacuation plans on their files so it was clear to staff and the emergency services how they would need to be supported in the event of an emergency. Staff were not aware of any contingency plan in the event the home could not be reoccupied following evacuation. The registered manager told us emergency procedures were available and staff would be reminded of these.

During our review of accidents and incidents we noted that one person had needed three staff to support them off the floor when they fell. We found there was no moving and handling equipment when this type of accident occurred to support staff to move people safely. The registered manager told us they would discuss equipment needs with health professionals and the provider.

Requires Improvement

Is the service effective?

Our findings

People said they felt staff had the skills required to meet their needs. One person told us, "They seem to know what they are doing."

The Provider Information Return we received from the registered manager stated, "All staff are fully trained to provide effective care meeting the needs of the individuals." We found training was planned to support staff development and to meet people's care and support needs. Staff had completed training in a number of areas and this was ongoing for some of the new staff. A training matrix confirmed staff training completed and this included moving and handling people, first aid awareness and infection control. The provider encouraged staff to gain nationally recognised qualifications such as National Vocational Qualifications in care to further support their practice within the home. Staff confirmed they had attended essential training and had access to other training if needed. One staff member told us, "They ask if there is any training I want to do such as NVQs (National Vocational Qualifications) and things like that."

New staff followed the provider's induction programme when they started working at the home to prepare them for their role. The registered manager told us the training was based on the 'Care Certificate' and records confirmed this. The Care Certificate helps new staff members to develop and demonstrate they have the key skills they need to provide quality care.

The registered manager told us she carried out observations of staff periodically to confirm staff competence following training they had completed. One staff member told us, "They test your competence. We have little discussions when we have all done the same thing (training) we will have a group meeting and she [registered manager] will ask us about it."

Our observations throughout the day showed staff supported people safely. For example, we saw how staff prompted and guided people to stand from their chairs and use walking aids whilst staff walked beside them. We also saw staff wearing protective clothing when carrying out their duties to help prevent the spread of infection within the home. This demonstrated their learning from training they had completed.

Staff told us they had attended supervision meetings with the registered manager to discuss their role and training. This was so any staff development needs could be identified and acted upon to assist staff in meeting people's needs. One staff member told us, "We have meetings every couple of months." They went on to tell us what was discussed and stated, "If I have got any problems, issues, am I happy here, any training I want to do. How do I think I am getting on with everyone." Staff told us they felt supported by this process.

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

interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The registered manager understood they had a responsibility to comply with the requirements of the MCA but we found through the review of records and speaking with people and staff that the principles of the Act were not always being followed. For example, we found a risk assessment showing a person was not to be given a certain drink. However, we were told the person had capacity and was able to make their own decisions but they had not been not been involved in this decision. Although staff believed they were acting in the person's best interests, this was not the case, as the person had not given their consent.

We identified people's had MCA assessments on their care files stating they did not have capacity. However, on reading care plans found that people were making decisions and had signed care plans to show their agreement suggesting they understood what was being asked of them. For example, in the care plan for one person with a mental health condition it stated the person "is able to make choices and decisions …. if kept simple." This suggested staff did not fully understand their responsibilities in regard to capacity and decision making.

The MCA and Deprivations of Liberty Safeguards (DoLS) require providers to submit applications to a supervisory body for authority to deprive a person of their liberty. We were told about one application that had been submitted but were told by the registered manager the person actually had capacity. This meant the application was not valid. Staff had received training in the MCA and Deprivation of Liberty Safeguards (DoLS) but it was evident this training had not been fully effective. A staff member spoken with knew that restricting elements of people's care could be a DoLS but was not able to expand any further about what this meant in practice.

We asked people about the food and drinks provided in the home and if they were given a choice. One person told us, "There is enough choice and the food is very good. I eat all of the food that is put in front of me." Another told us, "The food is okay."

Care staff completed the cooking and catering duties in the home. People were given the choice to have their meals in the dining room, lounge or their room if they preferred. People chose when to get up and have their breakfast. One person told us, "I usually have my breakfast in here (dining room) but at lunch time you can have your meal brought to where you are." They went on to say "It is the sort of breakfast I had at home." Another person told us, "If I want egg on toast, I can have it" demonstrating choices were provided.

The lunch time meal was a social part of the day when people got together in the dining room and chatted with staff as meals and drinks were prepared. People were independent with eating and drinking and staff had a good understanding of any risks around people's nutritional needs. For example, they knew about those people with diabetes and to watch the sugar content of the food provided to these people. They knew one person needed to have their food cut up into small pieces so they could eat independently.

People were provided with a choice of two main meals each day. We were told about one person who did not like specific food items and were particular about what they would eat. We saw the person was given alternative choices to accommodate their preferences. Food records confirmed they received a varied diet. We observed people's experience at lunchtime. The meals served looked appetising and after people had eaten their meals we heard them talking with one another commenting they had enjoyed them.

Staff had taken action for one person to see a health professional due to them not eating well and losing

weight. This was so an assessment of the person's needs could be undertaken and they could provide staff with advice on how to manage them. Records showed advice given by a dietician had been recorded in the person's records to help ensure staff followed it. One recommendation was for the person to be given a carbohydrate snack in the evening. When we looked at the person's food records we saw that a snack was provided sometimes in the evening but not all of the time. We discussed this with the registered manager who stated it was probably because the person was refusing the snack. However the records did not state this so we could not be sure the snack was offered consistently. There was also no indication of the person's favourite snack foods so that staff knew what the person would like to eat. There was no written guidance for staff on what they should do if the person refused to eat, other than offer encouragement. The registered manager said they would ensure staff recorded any refusals. We found there were other people who were not offered an evening snack routinely. This meant there was a long gap between the evening meal and the next morning. The registered manager said she would check people's needs and would provide snacks in accordance with people's wishes.

People had access to drinks and we saw arrangements had been made to support one person to make their own drinks independently. Staff knew that one person liked to have a specific cold drink with their meals and we saw this drink was provided. However, we saw other people were not always given a choice of drinks at lunchtime. People were asked if they wanted the orange drink that had been prepared but no other drink options were given. Similarly when tea was prepared for the morning drink, staff only asked people if they wanted a cup of tea with no other choices given. One staff member told us, "In the kitchen we have a list of drinks and what their requirements are and preferred options." We established this list had been prepared when people had arrived at the home. This did not take into account people's choices may vary on a day to day basis.

People told us they were able to access health professionals when needed and records confirmed this. People's care plans detailed their health history and contained instructions for staff to follow to support people's healthcare needs. Staff had accessed occupational therapists, dieticians and doctors for advice when needed. This included times when there were changes in people's health that were of concern.

Good

Is the service caring?

Our findings

People were positive about the staff and felt they were caring. One person told us, "I think they are very very efficient, there is nothing at all they wouldn't do for you. They are very good." Another told us, "Here it is as you see it, it's clean, people are friendly and people will say good morning that sort of thing, we get on fine."

One person told us they had been worried about coming into the home because they had a pet and they did not think they would be able to keep it at the home. They told us the provider had made an exception so that the person could live with their pet at the home. This showed that the provider and staff understood how important the pet was to the person to help with their emotional support needs.

Some people had developed positive relationships with staff and some had a laugh and a joke with staff which made everyone smile. People had the consistency of the same staff supporting them most of the time and people knew one another which helped them develop relationships. Staff told us they felt working at the home was like having an extended "family" because they knew people well. Staff told us they worked in a caring environment. One staff member commented, "I just love my job and caring for people. Just getting to know people." They went on to say, "Here it is more like a family." They went on to explain they felt this was because it was a small home where staff got to know people and their needs well.

We observed staff were caring in their interactions with people and provided help and assistance to people in a patient, calm and reassuring way. For example, one person was in pain and was presenting in a confused manner. The staff member asked the person to sit down and offered them some pain relief medication which the person accepted. They provided reassurance to the person and we saw they became calmer. Another person who was on their way to the dining room with the registered manager supporting them became dizzy. The registered manager supported the person to sit down and asked them if they would prefer to have their meal in the lounge which they did.

The Provider Information Return forwarded to us stated, "We actively encourage family members to visit at any time during the day. We do not have specific visiting times in place. Family members are encouraged to take their relatives out." We found this to be the case. People were supported to maintain relationships with those who were important to them and we saw visitors were welcomed into the home. One person told us, "I find it very good for people to come and see me."

People told us that staff were respectful and maintained their privacy and dignity and when we spoke with staff they knew about actions they should take to maintain people's privacy and dignity. For example, one staff member told us, "Make sure the door is shut and there is hot water in the morning when they get washed and dressed, make sure they are covered up." They explained how important "little things" were for people such as one person wanting to have certain creams applied and liked to be asked what clothes they wanted to wear. However, we observed that in practice, people's privacy and dignity was not always maintained. For example, one person's item of clothing was partially removed to apply cream within a communal area. The person was not asked if they wanted to go to their room and this practice did not promote the person's privacy and dignity. The registered manager advised action would be taken to

address this.

When we walked around the home we found that clocks in people's bedrooms had not been adjusted to the right time so that people could adapt their routines to the correct time of day. One person who was wearing a watch with the wrong time became confused about lunchtime because their watch had not been adjusted at the time when the clocks went back an hour. The registered manager told us this would be addressed.

Staff had not made sure people's privacy and independence was promoted and supported at all times.

Requires Improvement

Is the service responsive?

Our findings

People's basic needs were met but people did not always receive person centred care in accordance with their needs and preferences because staff had limited time to spend with them. People told us, "Most of us are sensible to realise you cannot always have what you want." Another said, "They are a bit slow…., they are not always as efficient as you would want them."

Staff understood the principles of person centred care, for example, one staff member told us, "Everyone has a right and a choice and everyone has to be respected as a person and an individual." However, staff did not always put the principles of 'person centred care' into practice. For example, one person presented as being confused at times, they walked from one area of the home to another and asked staff members what they should do. The staff responses did not enable the person to become engaged in an activity to settle and reassure them to meet their needs.

During the day when staff carried out tasks, they did not always check people's preferences such as what television channel they wanted to watch. During our visit the same channel was left on all day. One person told us, "In the lounge there is only one television and we all have a different idea what we want to watch." They went on to tell us what programmes they liked and said "If you feel miserable you can always laugh at those programmes." This showed how important the right television channels were for this person.

Sometimes actions were taken to ensure people's preferences were met. For example, in one care plan there was nothing about the person's interests except that they liked to read a newspaper. We noted the person had been given a newspaper. Staff told us about a person who had limited space to move around in their room so they suggested moving out a piece of furniture so they would have more space. This was done and the staff member told us, "It gives [person] more independence." We saw that when people complained the lounge was not "very warm" a staff member responded accordingly and checked the heating to make sure this was on and the lounge would get warmer.

People told us they chose the times they got up and went to bed. One person told us, "I usually tell them when I want to go to bed early and it is usually granted depending on the staff available at that time." The person suggested that sometimes if staff were busy with others they may have to wait. People said there were some social activities that took place within the home but these were limited. One person commented, "There isn't anything to do except go into the lounge and sit with other people and talk to them and watch television… they do a bit of activity like throwing a ball to you." Staff told us there were social activities that took place. One staff member told us, "We do activities daily, we do a weekly planner which we discuss with residents and what they like such as bingo, sing a long time, quizzes, skittles, pamper days and nails." They told us that most of the time an activity was provided.

The registered manager explained the importance of person centred care and told us they had taken people out of the home when they could. This included taking one person into the city centre so they could sit by the fountain which they enjoyed. However, the manager told us they could not do this for everyone and explained that providing activities in accordance with everyone's choices was a challenge. They told us this

was something they were in the process of trying to address. They advised the provider had been approached in regards to the provision of an activity co-ordinator with a view to improving person centred care. At the time of our inspection no agreements had been made in regards to an activity co-ordinator.

There were some links with the community such as 'church' services held within the home so that people's religious needs could be maintained. Some people also had advocate's to support them in making important decisions such as those related to financial matters.

The registered manager told us when a new person came to live at The Langleys, they gathered as much information as possible about them prior to their arrival. This information was then used to develop care plans for staff to follow to meet the person's needs.

The Provider Information Return forwarded to us stated, "All service users care plans are person centred, they take into account the residents spiritual and social needs as well as personal care needs." We found this was not always the case. Care plans varied in the amount of detailed information they contained. Sometimes there was clear information for staff to follow and at other times there was not. In some cases information recorded about people's needs was not up-to-date to help ensure staff met people's needs effectively. For example, staff explained how one person's mobility had reduced. Information in the person's care plan stated the person was able to "mobilise well". The reviews of the care plan did not mention any deterioration in their mobility. However, we were told the person had been seen by a doctor to try and determine why the person's mobility had deteriorated. The person also had a frame to aid their walking.

We noted the same person had skin problems. There was no information or explanation in the person's skin care plan about the red and broken skin areas. Staff told us they had previously responded to the person's skin problems by arranging for them to see a district nurse. However, these visits had stopped because the person's skin had improved. Although staff knew about the skin problems, there was no clear information to show how these were being managed to ensure they responded to them in a consistent way.

Staff told us they got to know about changes to people's health and people's choices through information shared at 'handover' meetings that took place at the beginning of each shift. However, we could not be confident information of concern was always shared. For example, we saw one person became dizzy when they walked to the dining room and had to be supported to sit down. This information was not passed on to staff coming on duty for the next shift so they were aware of this and the need to monitor them. The registered manager said this should have been recorded and passed on. They said staff would be spoken with to remind them about this.

People told us they had not made any complaints about the service. People said they would approach the registered manager if they had any worries about living at The Langleys. The registered manager told us every person who lived at the home received a copy of the provider's complaints policy and procedure. We saw copies were available in people's care plans but they did not contain all of the necessary information to support people to make a complaint. For example, there were no contact names and telephone numbers of people to speak with should people wish to escalate their concerns to the Local Authority and ombudsman.

We asked staff what they would do if a member of the public or person approached them with a complaint. One staff member told us, "Pass it to the manager or speak to the manager." Staff were unclear about where to record a complaint and the registered manager said this would be addressed.

Requires Improvement

Is the service well-led?

Our findings

People were positive about living at the home, one person told us, "This place is always clean and tidy and the beds are comfortable." Another told us, "I think we are very well looked after and very well cared for." We saw people were at ease to approach staff to make requests if they needed anything. One person told us, "I only have to make an enquiry and it would be sorted for us. No problem whatsoever."

The provider had made arrangements for people to be involved in decisions about the service during 'resident' meetings where people were asked for their opinions about the home. We saw notes of a meeting showed they had been asked about the range of activities provided and discussed the recommendations made by 'Healthwatch' following their visit to the home. It was not always clear from the 'resident' meeting notes that actions following these meetings were completed although the registered manager was able to confirm this.

Since our last inspection, the provider had made some improvements to the home such as the refurbishment of the laundry and improving infection control across the home. We noted these improvements during our visit.

The registered manager told us the provider regularly visited the home and worked with them to ensure the quality of care and services was maintained. The Provider Information Return (PIR) received by us prior to our inspection stated, "Staff communication in the home is good and we all reflect on the needs and changes within the home and the residents needs through regular meetings and hand over sheets..... I carry out monthly audits on the home ensuring the safety, maintenance and infection control is at a high standard. I review all care plans on a monthly basis and communicate with all staff if changes are made to care needs."

We found the actions as stated in the PIR were not always maintained. For example, communication systems were not always effective. We identified during the handover process, important information about a person was not shared. Audits to check the quality of the service had not been consistently effective in identifying areas for improvement. For example, the registered manager said staff were supported to understand their responsibilities by using the policies and procedures in the home to work safely. We found staff did not always follow the provider's policies and procedures. Staff were not clear about all of their responsibilities such as completing accident and incident forms when they occurred so they could be monitored to check sufficient actions had been taken keep people safe. They were also unclear on safeguarding people reporting procedures.

The registered manager said they carried out observations of care staff when working to make sure the policies and procedures of the home were followed. However, these observations were not recorded to show areas needing improvement were being identified and acted upon to keep people safe. The registered manager acknowledged the improvements required and told us staff would be reminded of the expectations of the provider in regards to the policies and procedures of the home.

Duty rotas did not contain the hours worked by the registered manager and were not sufficiently clear to demonstrate enough care staff were available at all times to support people's needs. For example, on one duty rota a senior care staff member was indicated to be the "cook all day" from 8am to 9pm. It was not clear if this person would be carrying out any caring duties during this time, but we identified from discussions with staff this happened. The same applied to the care staff member who was indicated on the duty rota to do "domestic" duties. This meant the provider could not assure themselves there were sufficient care staff available at all times to support people's needs. Unclear rotas meant we also could not be sure the home was being managed by a senior member of staff or the registered manager at all times. The registered manager agreed to address this and told us they were always available "on call" to staff if needed in an emergency situation.

People spoke positively of the registered manager, one person told us, "She is fine, she is a busy lady, she has been off sick recently we did miss her." Another told us, "She is a very nice lady." Staff were also positive about the registered manager. One staff member commented, "Very good, because it's a small home she knows everything that is going on, she is very approachable. If you had a problem she is very good that way and she listens to everything we have to say."

Staff told us they had regular staff meetings with the registered manager where they felt able to put their views forward if asked about issues related to the home. One staff member told us, "If there are any concerns, we are confident we can speak up in the meetings and talk about it." Staff told us that during one of these meetings they had been asked about uniforms and if they wanted to wear them. They had also discussed plans for people's birthdays and Christmas so they could celebrate these occasions.

The provider's quality monitoring systems included the use of regular satisfaction surveys. These were issued to people, relatives and staff for their opinions of the home. We noted feedback from the staff surveys showed a 100% positive response. The registered manager told us the results from the survey carried out with people were in the process of being analysed. However, we were informed people had been assisted by staff to complete them which can influence people's responses due to staff not being independent from the service. We discussed this issue with the provider with a view to this process being reviewed.

Arrangements were in place to ensure maintenance issues identified around the home were addressed to keep people safe. There was a maintenance person who worked at the home for 12 hours per week. Sometimes maintenance tasks were not signed off to show they had been actioned in a timely manner. The registered manager told us some of the tasks had been completed and some were ongoing.

The registered manager and provider understood the requirements of their registration and their responsibilities to provide quality care and support to people. They had returned their Provider Information Return when requested and understood that they were required to submit information to the Care Quality Commission (CQC) when reportable incidents had occurred.