Diamond Care Homes Langdales Ltd

Langdales

Inspection report

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18 July 2017

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection visit took place on 18 July 2017. The visit was unannounced.

The inspection was prompted in part by notification of an incident, when the location was owned by a different provider, following which a service user died. This incident is subject to a separate investigation and as a result this inspection did not examine the circumstances of the death. However the information shared with CQC about the incident indicated potential concerns about the management of health issues. This inspection examined those risks.

Since the incident the ownership of Langdales changed hands in April 2017. The registered provider is now Diamond Care Homes Langdales Ltd. We carried out this focused inspection to ensure the new provider was managing people's health issues. This report only covers our findings in relation to the potential concerns. As they have not yet had a comprehensive inspection as this new organisation, they have not been formally rated.

We spoke with four people who told us they felt safe and 'well looked after' by the staff team.
We looked at care and support of people who needed assistance with personal care. We checked care records of people who were at risk of skin breakdown and pressure sores. We saw care plans, risk assessments and daily reports indicated checks had taken place. Repositioning charts to record the person's positional changes were used where needed.

Pressure aids were in place where people were at risk of developing pressure sores. Action was taken and support and guidance sought where people were at risk of tissue damage.

We looked at how staff received information and guidance. We saw staff received supervision and staff meetings took place with records kept. Any care issues or changes were highlighted to staff in both individual supervision and staff meetings. Staff training in the care of people at risk of pressure sores had been sourced and arranged so staff had up to date knowledge of current care and guidance.

Audits were frequent, documented and any issues found on audits acted upon promptly. Audits were forwarded to the directors of the organisation who checked actions were taken where needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People we spoke with told us they felt safe at Langdales.

Staff monitored and responded to people's health needs to keep them safe.

Staff were familiar with people's needs. Care records were informative, specified the risk and action and care needed to keep people safe.

Is the service well-led?

Good

The service was well led.

The registered manager encouraged staff to reflect on care practice at staff meetings and supervision in order to learn from incidents and events.

The registered manager had sought additional training to assist in providing staff with the skills and knowledge needed to provide safe and timely care.

A range of quality assurance audits were in place to monitor the health, safety and welfare of people who lived at the home. Any issues found on audits were quickly acted upon.

Langdales

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.
The inspection was prompted in part by notification of an incident, when the location was owned by a different provider, following which a service user died. This incident is subject to a separate investigation and as a result this inspection did not examine the circumstances of the death. The information provided to CQC indicated potential concerns about the care of people in the home. We needed to check fundamental standards were in place to keep people safe.

This inspection visit took place on 18 July 2017 was unannounced. The inspection team consisted of an adult social care inspector.

Before our inspection on 18 July 2017 we reviewed the information we held on the service. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people the service supported. We checked to see if any information concerning the care and welfare of people who were supported had been received.

We spoke with four people who lived at the home and observed staff carrying out their duties in the lounge and dining room. We also spoke with a senior manager, the registered manager and three staff members. This helped us to gain a balanced overview of what people experienced accessing the service.

We looked at care and support records of two people who needed assistance with personal care, the services training and supervision records and staff meeting records.

Good

Is the service safe?

Our findings

The focused inspection was prompted by a notification about a person using the service who had a pressure sore on admission to hospital from the home. When we undertook this inspection visit there was an on-going investigation in relation to an individual's healthcare by CQC, the local authority safeguarding team and Coroner's office. The service was working in cooperation with these authorities to provide information and address any concerns. This was not part of this inspection. However this inspection was carried out to make sure other people in the home were supported promptly and safely.

Staff had received safeguarding training and understood the process to follow to report any concerns about people's safety. They told us they would report any unsafe care or abuse. The registered manager was aware of the process for notifying the local authority safeguarding team and CQC of any safeguarding issues. They knew the types of concerns that needed to be notified.to CQC. People said they felt safe and comfortable with the staff who supported them. One person said, "I do feel safe here. They are all lovely and 'smiley'." Another person said, "I am well looked after here. Of course I am safe."

We looked at how staff monitored and responded to people's health needs to keep them safe. We checked two care plans of people who were at risk of tissue damage. One person had arrived from hospital with a sore and infected big toe. This had not been on their hospital discharge notes but found on admission to Langdales. Hospital staff confirmed the toe had been infected in hospital. Langdales staff team took appropriate action. They contacted the person's GP who prescribed treatment and the district nurse became involved in the person's care. Staff checked the condition of the toe regularly to ensure it remained clean and dressed. This gradually improved. Daily records confirmed regular checks had been carried out. Also staff were reporting any mark on a person's skin to senior care staff and the District Nurses. We spoke with staff who knew the care they needed to provide to the person. We were unable to talk with the person on the inspection as they were out of the home.

We also looked at the care records of another person who was at risk of pressure areas due to limited mobility. Records showed the areas at risk were regularly inspected for any marks or sores. These showed there were none when we inspected. However staff had recorded there had been a small area of concern recently. Staff had made extra checks to make sure the area did not break down. They also gave encouragement to the person to move about regularly. We saw the person was supported to move safely during the inspection.

Risk assessments were in place for both people. These informed those involved with their care of any concerns and actions to take to reduce risks. They had been reviewed and updated regularly. We spoke with staff about lessons learnt from the recent incident. Staff told us they checked people more regularly and made sure they recorded it. One member of staff said, "We check, check and check again and write everything down." Another member of staff said, "Any concerns at all and we tell senior staff."

A member of staff had rung in sick earlier on the morning of the inspection. Although this meant staff were busy, people were still supported promptly if they requested help. The registered manager assisted staff by

overseeing people in the lounge and with meals at lunchtime so meals were not delayed.

Good

Is the service well-led?

Our findings

We undertook this focused inspection on 18 July 2017 to check senior staff were providing governance of the home and carrying out regular audits to monitor care in the home.

There was a registered manager in post. They were on duty during the 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.

We checked that senior staff monitored the care and support staff gave to people. Also where required, that they provided information, guidance and additional training to staff. We looked at how messages were passed to staff about any changes in care. We saw there were daily handovers and a communication book alerting staff to check information and changes. Memos were sent to staff on particular issues, staff meetings were held and staff had regular supervision.

We looked at the supervision records and staff meeting records to see how information was circulated to staff. We saw for example, tissue viability and pressure area care had been highlighted to staff in both individual supervision and staff meetings. Monitoring and checks of people susceptible to pressure sores and recording of such checks was discussed. This included discussions on pressure area care, repositioning, food and fluid charts and accurate record keeping. Staff were reminded to report any mark of concern on the person's skin to senior staff in the home and the District Nurses.

Reflective discussion and lessons to be learnt were part of meetings. Records had been made of the meetings and supervisions so individuals were clear about the discussions and guidance given. The minutes of staff meetings were available to all staff so all staff had information on the main issues discussed. Therefore absence from the meeting did not prevent staff knowing about issues or changes in care. The registered manager had sourced and arranged additional training in the care of people at risk of developing pressure sores staff had up to date knowledge of current care and guidance. She also informed us that staff were reporting any mark on peoples' skin to senior care staff and district nurses.

The new organisation management team had systems in place to assess and monitor the quality of their service and the staff. A senior manager visited the home regularly to monitor care and provide support and guidance. Audits were frequent, documented and any issues found on audits acted upon promptly. Audits were forwarded to the directors of the organisation who checked actions were taken where needed.