

Mr B O & Mrs C N Ogbakaeko

# Langdale Court Care Home

## 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 carried out an unannounced inspection of the service on 07 November 2017.

[Langdale Court] 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. (The care home) accommodates seven people in one adapted building. There were five people with mental health issues receiving care and support at the home at the time of our visit.

The service was last inspected 25 August 2015 and the rating for that inspection was Good.

There was a manager registered with the Care Quality Commission (CQC). 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 registered manager was not available at the time of the inspection.

People continued to feel safe. Risks were assessed and managed. There was enough staff to meet people's needs. Safe recruitment was followed to ensure suitable staff were employed.

Medicines were managed and stored safely. Arrangements were in place to make sure the premises were clean. Staff had completed relevant hygiene training. Incidents and accidents were reported and managed.

People continued to have their needs assessed. Staff received training to ensure they had appropriate skills to carry out their roles. People were supported to have sufficient to eat and drink. People were supported to receive care across different services. People were involved in regular monitoring of their health and wellbeing. People were consulted about decisions about their environment. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

People were positive about the staff and the care they received. People were treated with respect, compassion and in a dignified way at all times by the staff who cared for them. Staff were encouraged to form caring relationships with people to make sure they experienced good care.

People continued to receive personalised care that met their needs. Concerns and complaints were listened and responded to. Discussions took place to support people at their end of life.

Systems and procedures were in place to monitor and improve the quality and safety of the service provided. There was a registered manager in post. Staff were supported to raise concerns and use the whistleblowing policy. Information systems are used effectively to monitor the quality of care.

The service works in partnership with other organisations including the local authority, safeguarding and CQC.

## 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 was safe.

The service remains Good.

Good ●

### Is the service effective?

The service was effective.

The service remains Good.

Good ●

### Is the service caring?

The service was caring.

The service remains Good.

Good ●

### Is the service responsive?

The service was responsive.

The service remains Good.

Good ●

### Is the service well-led?

The service was well-led.

The service remains good.

Good ●

# Langdale Court Care Home

## Detailed findings

### Background to this inspection

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

The inspection was a comprehensive inspection, which took place on 7 November 2017 and was unannounced. The inspection team consisted of one inspector 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, 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 provider returned the PIR and we took this into account when we made our judgements in this report. We reviewed other information we held about the service such as notifications, which are events which had happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority who commissioned services from the provider.

During our visit we spoke with four people who used the service. We spoke with two members of staff and the provider's representative.

We looked at all or parts of the care records for three people, the training and induction records for three staff and two people's medicine records along with other records relevant to the running of the service. This included policies and procedures, records of staff training and records of associated quality assurance processes.

We also consulted other professionals and commissioners of the service who shared with us their views about the care provided.

## Is the service safe?

### Our findings

People continued to receive safe care. One person said, "Yes, I am alright here, everything is alright." Another person said, "Everything is reasonable."

People lived in a safe environment. People were protected from harm as staff understood their responsibilities to safeguard people from the risk of harm. Staff described and identified different signs of abuse and the action they would take to report and document any concerns. Staff told us and records confirmed they had received safeguarding training. Records we looked at also confirmed safeguarding training was up to date. The provider's representative told us, the registered manager had taken action to report and investigate allegations of abuse and issues of concern. The provider's safeguarding policy and procedures had been followed when incidents were reported to the local authority or the police.

Safeguarding was discussed at staff and resident meetings. Records we looked at documented these discussions had taken place. The safeguarding processes and procedure information was shared with people. This included how they should report issues should they have any concerns.

People's needs were assessed. Risks were identified and managed. Risk assessments reflected people's current needs. Staff were provided with clear instructions in care plans to mitigate the assessed risk. For example, one person went out in the community and was at risk of as at times they begged for food. Staff mitigated the risk by providing a packed lunch each time the person went out. The risk assessments and care plans were regularly reviewed as people's needs changed.

Systems were in place in case of an emergency, such as risk of fire. There was an emergency evacuation plan for each person which was easily accessible. The person responsible for the environmental checks told us and records we looked at confirmed that weekly fire tests and monthly checks of equipment were carried out. This was to ensure they were in full working order should an emergency occur. One of the three fire exits was accessible through a bedroom. This room was not occupied at the time of our visit. There were plans in place to manage any issues that occurred should the room become occupied. This meant people were able to leave the building easily in an emergency.

There were enough experienced staff to keep people safe. People felt there was sufficient staff to meet their needs. Staff told us they felt there was enough staff working at the home. One staff member said, "We have sufficient staff. If needed other staff cover absences."

The provider's representative told us there were systems in place to ensure they had sufficient staff on duty to meet people's needs. This was reviewed and monitored on a regular basis. They said that any shortfalls would be covered by other staff. We observed people's needs were attended to in a timely manner as there were enough staff on duty. The staff on duty did not match the staff on the rota at the time of our visit. The provider's representative told us this was being dealt with as a member of staff was absent and the rota had to be updated. We checked that the rota had been amended to identify current staff working at the time of our visit. We observed staff interacted well with people and each other and worked well as a team.

The provider followed safe recruitment practices, which helped to protect people from unsuitable staff. Safety checks had been made to establish that staff were of a suitable character to provide people with care and support. Records showed that staff had the appropriate checks and references in place. These included written references and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

People received their medicines as prescribed and were given them by trained staff who ensured medicines were administered on time. People commented they received their medicines on time. Some people were able to identify what they were taking their medicines for. One person told us their medicines had been changed recently by their GP.

Staff who administered medicines received appropriate training and had a good understanding of the policy and procedures for administering medicines to people. The provider's representative told us staff were assessed for their competencies to administer medicines once they had completed medicine training successfully, to ensure they were confident and competent to do so. Records we looked at confirmed this.

There were regular audit checks of medicines and medication administration records (MAR) to ensure people received their medicines as prescribed and on time. As required medicines (PRN) had person centred protocols put in place. Medicines were stored safely and in line with relevant guidelines.

People were protected from the risk of infection as the provider had infection control procedures for staff to follow. Arrangements were in place to ensure the provider was following relevant guidance for infection control and made sure the environment was clean and free from infection. People told us the home was clean. Staff described the equipment used in line with current guidance for infection control. For example, gloves and aprons were worn when changing bed linen. All staff had completed a food hygiene course to ensure they prepared and stored food correctly.

Incidents and accidents were managed and recorded appropriately. There were policies and procedures in place to manage risks and staff followed these to protect people. The provider's representative told us they were implementing a procedure to gather and analyse incidents and accident information. This was to ensure they learned and improved when an incident occurred.

## Is the service effective?

### Our findings

People received care and support which was delivered in line with current standards and guidance. People's physical and mental health was assessed on a regular basis.

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. All staff were inducted to the service when they first started working at the home. New staff underwent an induction which included spending time with other experienced staff; shadowing them to enable them to get to know the people they were supporting. Records showed that staff had attended relevant training courses to support them in their role. For example, understanding behaviours that challenge and diabetes awareness. Staff received supervision where they discussed training and received support from their manager.

Staff told us they received supervision and appraisals and that they were able to discuss areas for development, reviews of performance and delivery of care. One member of staff told us, "I have supervision on a monthly basis. I feel supported by the management and if needed I can contact them at any time." Records of supervision we looked at identified that the management discussed staff learning and development. However we found some supervision's had not been completed since July 2017. This meant some staff had not received supervision for four months. We spoke with the provider's representative and they told us this was an oversight. They told us plans were in progress to improve the regularity of staff supervisions. They said they speak with staff on a daily basis and have an open door policy for them to raise any issues or concerns.

People were assessed for their risk of not eating and drinking sufficiently to help maintain their health and wellbeing. People told us the food was OK. One person said, "It's alright, I get plenty. You can have whatever you want. The staff cook every day." Staff told us people could have what they liked. They provided a menu each day, but if a person preferred something else they can have it. There was sufficient food in the food store. Fresh produce was available.

We observed there were set times for drinks throughout the day. People could also ask at any time for a drink or snack outside these times. Staff informed us these set times were to ensure people received sufficient drinks and food to keep them nourished and hydrated.

People were supported to discuss their health needs with the service and across other organisations to ensure people received effective care and support. One person had a healthy eating plan in place, which had been devised by a dietician. Other people had given up smoking with the support of the staff and the persons GP. Staff contacted the emergency services where people required immediate medical attention. For example when they were admitted to hospital. There were clear systems in place what referring people to external services.

People's health needs were monitored on a regular basis and staff ensured that any changes to people's health were communicated to staff at each shift handover. The service liaised with health care professionals

for example, district nurse and dietician.

People were involved in decisions about the premises and environment. People were consulted and expressed their choice of colour when the home or their bedroom was decorated. Copies of resident meetings confirmed these discussions had taken place. People were able to access the outside space at the front and back of the home independently.

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. We checked whether the service was working within the principles of the MCA.

Care records confirmed detailed capacity assessments had been completed and reflected a holistic approach for each individual decision about the care requirements of people. Where best interest's decisions were required these had been completed and confirmed any relevant professionals had been involved. Efficient and robust systems were in place to ensure appropriate DoLS applications if necessary would be submitted to the assessing authority.

## Is the service caring?

### Our findings

People continued to experienced positive caring relationships with staff and other people living in the home. People were treated with kindness and compassion by the staff. One person said, "They [Staff] call me by my preferred name. Another person told us they liked living at the home. They said, "Best as it can be, everything is okay."

Staff told us they ensured people were treated with kindness and respect. Staff had a good knowledge of people's needs and preferences. Staff demonstrated they communicated with people effectively by spending time with people. Staff were aware of the risks of discrimination and treated people with respect no matter of age, gender or sexual orientation. We observed staff attending to people's requests. For example, one person requested some money as they were going out for the day. Staff knew individuals well and supported them effectively. We observed the atmosphere of the home was calm and staff were caring and kind. Staff encouraged and engaged people to actively be involved in sharing their views on what they wanted to do throughout the day. For example, where people wished to stay in touch with family and friends they were supported to do so.

People received information about external bodies, community organisations and advocacy. Staff told us they used an advocacy service and accessed relevant information when needed. They gave an example were an advocacy service had been used by one person living at the home. An advocacy service is used to support people or have someone speak on their behalf. Advocates are trained professionals who support, enable and empower people to speak up.

People received care from staff that preserved their dignity by ensuring they were discreet when offering personal care. One person said, "They [staff] treat me with respect." Another person said, "They [staff] give me my medication in private, in my room." When people wished to be left alone staff respected their wishes. One person told us they can sit where they wanted and be by themselves if they chose.

Care plans reflected people's needs and what was important to them. One person had expressed they wanted to reconnect with more of their family members. Staff told us they supported the person to do this by encouraging them to use the telephone. This told us people's personal preferences were incorporated in their day to day activities.

The provider's representative told us staff were observed in relation to how they talked to and treated people on a daily basis. We observed staff being respectful during our visit. All of the interactions between staff and people using the service were good humoured and natural. Staff asked people's permission before we looked at their bedrooms. This showed us people were respected and their views were taken into consideration.

## Is the service responsive?

### Our findings

People continued to receive care that met their individual needs. People's needs were assessed to determine if the service could meet their needs.

Records we looked at confirmed care was planned and detailed to ensure people's needs were fully met. People were aware of their care plan reviews. Comments made during conversations with people confirmed that people knew they had a care plan, however could not remember if they had been involved in any discussions about their care. Care plans showed people had been involved with these discussions and they had signed to say they agreed with their care needs.

People expressed their likes and dislikes and preference in their care plans. Staff told us they provided care that met people's preferences. Staff had documented in care plans times people preferred to get up or go to bed. We also spoke with the kitchen staff who were fully aware of people's dietary needs and knew what foods people liked and disliked.

People were encouraged to go out in the community independently. This helped them to learn life skills for independence. For example, people went shopping for clothes. They also went to the cinema and to visit family and friends. People were supported to follow their interests and hobbies. This showed us staff supported people to achieve their goals and aspirations.

People were confident that they could make a complaint. One person said, "I would speak to staff, they're okay." Another person told us they had not had any complaints, but would be okay if they did, they knew who to raise concerns with.

The provider enabled people to share their experiences, concerns and complaints and acted upon information shared. The service had a complaints procedure and complaints log to monitor concerns and complaints. Complaint policies and procedures were also discussed at resident meetings. This identified to people what they should do if they wished to make a complaint and how they should do this.

We saw where concerns had been received. They had all been followed up and responded to in a timely manner. One complaint had been received in the last 12 months. Action had been taken. The provider had acknowledged that the language used in formal responses to complaints had not always been appropriate and was in the process of reviewing this.

People had the opportunity to discuss with staff their end of life wishes should this be required. People had expressed their own preferences what they wanted to happen at their end of life and advance arrangements in the event of their death. For example, one care plan recorded what music a person wanted at their funeral. This also included details of how and where they wanted to be buried.

## Is the service well-led?

### Our findings

There was a manager registered with the Care Quality Commission (CQC). 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 registered manager carried out their role of reporting incidents to CQC.

The service had a positive culture that was person-centred, open and inclusive. People were observed to be happy with the way the home was managed. One person said, "It's okay, perfect." Staff were complimentary about the service and the way it was run. One member of staff said, the management were approachable." They also told us the service provided was good.

Staff were aware of the provider's whistleblowing policy and procedure. A whistle-blower is protected by law to raise any concerns about an incident within the work place. Staff told us they understood the policy and felt comfortable to use the policy if required to do so.

The provider had systems in place to monitor the quality of the service. This included gathering, recording and evaluating information by completing monthly audits, such as, for medicines, and the environment of the home. Where issues were identified the provider always had action plans and systems to follow these up and check that the issues had been resolved. The provider's representative told us they had learned lessons by sharing practice with another of their homes. They showed us where improvements had been made to the premises.

Quality Assurance surveys were given out yearly. However people could not remember completing them. We saw that staff and resident meetings had taken place. We looked at copies of minutes from these meetings. These showed the meetings were informative and helped to keep people and staff up to date about people's needs, and what was happening in the home. There were discussions around roles and responsibilities including night staff.

The registered manager took the opportunity to share good practice at team meetings and introduce specific policies or training subjects to inform staff of people's specific needs. Where updates were need on specific equipment or improvements to the home these were part of the meeting agenda. For example, Improvements to the home, including redecoration of some bedrooms. We saw discussions had been held with people and they were involved in colour choices.

The provider told us through the provider information return (PIR) that they intend to introduce more keyworker and 1:1 sessions with the people who use the service. Within the next 12 months they planned to send staff on training relating to key-working to enable them to be better equipped for the role and 1:1 sessions with the people. This was to give staff more confidence and responsibility.

The provider's representative and manager monitored the service on a regular basis for the quality of care

they provided. For example they carried out audits on medicines, cleanliness and the environment.

The service was cooperative, transparent and open. They shared information with relevant organisations to develop and deliver joined up care. When a person goes into hospital the home ensured a grab sheet with all relevant information relating to the persons condition was available to the hospital staff. For example, if a person lived with a condition, such as, diabetes or Chronic Obstructive Pulmonary Disease (COPD).