Care Quality Commission

# Langley Court Rest Home Limited

# Langley Court Rest Home

**Inspection report**

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires improvement |
| Is the service safe? | Requires improvement |
| Is the service well-led? | Requires improvement |

## Overall summary

This inspection took place on 20 April 2015 and was unannounced. At the last inspection on 17 October 2014 we found the provider to be breaching regulations in relation to care and welfare, medicines management and assessing and monitoring the quality of the service provision. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Langley Court Rest Home on our website at www.cqc.org.uk.

Langley Court Rest Home provides accommodation and personal care for up to 28 older people, many of whom live with dementia. On the day of our visit there were 24 people living in the home.

The home had a registered manager. 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.

At this inspection we found the service had not taken sufficient action to improve medicines management to keep people safe. When we checked medicines stocks we could not always confirm people received their medicines as records showed. In addition, staff who administered medicine were not always able to focus on carrying out this task. During our inspection this meant medicines

# Summary of findings

were administered late and this could also be a cause of medicines errors. Although we found required improvements in relation to medicines storage had been made we found the service was in breach of the regulation in relation to safe care and treatment. You can see what action we told the provider to take at the back of the full version of the report.

Required improvements had been made to risk assessment and care planning in relation to pressure ulcer management and choking. Risk assessments to identify risks to people and care plans to guide staff as to how to provide care to people safely were in place and regularly reviewed.

We found the safety of the premises had improved. This was because alarms had been installed on fire doors. This meant that should people who required staff support to remain safe outside the home leave the premises alone staff were alerted and could provide support.

Systems to audit the quality of the service had improved in relation to checking care. However, systems to check the safety of medicines management remained ineffective in identifying concerns.

# Summary of findings

## 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 not always safe. Medicines management was unsafe because we could not always confirm medicines were given to people as records indicated. In addition, staff who administered medicines were not always able to focus on this task and did other tasks such as dealing with visitors. During our inspection this caused medicines to be administered more than three hours late to people and could be a cause of errors and omissions.

However, action had been taken to improve care planning as required at our previous inspection. Where people were at risk of choking and developing pressure ulcers, care plans and risk assessments were not always in place previously but the provider had rectified this issue.

The safety of the premises had been improved as alarms had been installed on fire doors. This meant staff were alerted when people who required support when outside left the home alone.

**Requires improvement**

**Is the service well-led?**

The service was not always well-led. Although the home had made some improvements to their systems to audit the quality of the service, systems to check medicines management remained ineffective.

**Requires improvement**

# Langley Court Rest 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.

This inspection was undertaken to check that the provider had made improvements to meet legal requirements after our 17 October 2014 inspection. We inspected the service against two of the five questions we ask about services: Is the service safe? Is the service well-led? This is because the service was not meeting some legal requirements previously.

This inspection took place on 20 April 2015 and was unannounced. It was undertaken by an inspector.

Before our inspection we reviewed information we held about the service such as the action plan the provider submitted setting out how they would meet the breaches identified at the previous inspection.

During the inspection we observed how staff interacted with the people who used the service. We spoke with two people using the service, the director, the deputy manager, three members of staff and a district nurse not employed by the service. We looked at six people's care records and records relating to the management of the service including quality audits.

Requires improvement

# Is the service safe?

## Our findings

At the last inspection we found a breach of the regulation in relation to medicines management. At this inspection we found, although the service had made some improvements, there remained a breach in relation to this. We checked stocks of five medicines with staff. For one medicine there were two tablets less than expected. Staff and the person whose medicine it was were unable to account for this. This meant we could not confirm the person had received this medicine as records indicated. As this medicine is indicated to manage pain, this suggested the service was unable to monitor whether the person's pain was being managed appropriately.

We observed staff administering medicines to two people and saw that they were being administered three hours late. Administering medicines late can mean these are less effective in treating the medical condition which they are prescribed for. Staff told us they had been busy with other tasks including seeing visiting professionals. We spoke with one person who received their medicines late. They told us, "I don't know why it's late today. I came down for breakfast." We asked them if this had happened before and they told us, "No, this is a one-off." Staff recorded the actual time they administered the medicines on the back of the medicine administration record (MAR). This meant there was an accurate record of the times people received medicines to enable staff to check sufficient gaps had been left between medicines administered.

In addition, we noted the staff administering medicines answered the door to us during their medicines round when we arrived for the inspection. It is well documented that staff doing the medicines round should avoid doing other tasks as this could result in errors being made. When we raised our concerns with the deputy manager they told us medicines administration should be a 'protected task'. This meant staff administering medicines were expected to focus on this only and not do other tasks. They told us they would investigate how to support staff to ensure medicines administration remained a protected task and they were not distracted by other tasks such as dealing with visitors.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection a controlled drug was not being stored in accordance with the Misuse of Drugs Act, to prevent it being misused. However, at this inspection we found action had been taken to ensure appropriate storage of controlled drugs. The controlled drugs in stock were not administered by staff at Langley Court but by community nurses who visited daily. However, we found the home ensured an accurate record of controlled drugs in stock was maintained, with clear records made of drugs received by the home.

Previously we found staff had not signed the MAR before administering medicines. However, at this inspection we found no incidences of this. We also found no omissions in staff signing the MAR.

At the last inspection we found a lack of guidance as to when staff should administer an 'as required' (PRN) medicine to a person when they became anxious. However, at this inspection we found staff had stopped administering this medicine to the person. The service had worked with the person and understood their anxieties better. They had learnt what the person wanted to communicate through certain behaviours, such as physical pain due to a medical condition. They had systems in place to respond to this person's needs which involved massaging and other specific assistance with their condition. Guidance was in place for staff to follow regarding this.

Staff received regular training in medicines administration, with focused training for staff who required additional support. The director told us he planned to introduce competency assessments for staff to check they were able to administer medicines to people safely.

At the last inspection we found a breach of the regulation in relation to care and welfare as risk assessments and care plans were not in place for pressure ulcer prevention and management. In addition, two people had been assessed by a speech and language therapist (SLT) as being at risk of choking when eating, although no choking risk assessments or care plans were in place which were regularly reviewed or updated. These issues meant people may have been at risk from inappropriate care planning. At this inspection we found the service had made the necessary improvements. The service had assessed the level of risk for all people of developing pressure ulcers and

Requires improvement

# Is the service safe?

these assessments were regularly reviewed. Where people were found to be at risk care plans were in place to guide staff as to how to reduce the risks of them developing pressure ulcers.

The district nurse told us staff always referred people for nursing support when necessary, for example if they were concerned they may have developed a pressure ulcer. When one person had a pressure ulcer a specialist nurse (a tissue viability nurse) visited them daily. The district nurse told us the service were doing everything they could to support this person and they were not concerned this pressure ulcer was due to the service supporting them inappropriately. Specialist equipment to reduce the risk of pressure ulcers, such as pressure-relieving mattresses and cushions had been provided and the nurse told us the home's staff used these appropriately.

Where people were at risk of choking, risk assessments and care plans were in place for staff to follow in providing appropriate support to people which were regularly reviewed. Guidelines from SLT remained accessible for staff to follow, which summarised how staff should provide support. This meant people were at lesser risk from inappropriate care planning in relation to this.

At the previous inspection we found risks in relation to the health and safety of the premises were generally well managed. However, there was unsecured and unmonitored access to a fire-escape leading to the car park through a fire door. This was a risk as many people at the home were disorientated to time and place due to dementia and required staff support when leaving the home. However, at this inspection we found the provider had installed alarms on all fire doors across the home which staff demonstrated were working and were regularly checked. This meant staff would be alerted should people attempt to open these doors and go outside the home.

Requires improvement

# Is the service well-led?

## Our findings

At the last inspection we found that the audits in place had not identified the issues we found in relation to care planning and medicines management. At this inspection we found some auditing systems had improved, although medicines audits had not identified the issues we found at this inspection. Senior staff continued to audit medicines practices once a week, including regular stock checks of small samples of medicines. When they found errors and omissions they recorded these clearly in a log and took necessary action to keep people safe. However, this sampling method and frequency of auditing had not identified the issues indicating a person had not received their medicines as records showed. The deputy manager told us they were considering introducing a new system to record medicines remaining in stock after each medicines round. However, plans had not been finalised for these.

The contracting pharmacy had recently carried out an audit of medicines practices in the home. We reviewed their findings which stated the service was managing medicines very well, with protocols in relation to storage and administration being followed. However, some actions for improvements were suggested, such as obtaining an additional medicines trolley to make locating medicines easier. The director told us they were taking on board all the suggested actions and they had agreed the pharmacy would regularly audit the service in the future.

The deputy manager told us a member of staff who was a trainee nurse reviewed the care plans and risk assessments regularly to ensure they remained up to date and accurate. However these audits were not recorded which meant we could not evidence their effectiveness.

The director told us they were considering introducing an enhanced quality auditing system where a suitably competent person would check all aspects of service provision on a regular basis, but this was not yet in place.

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment<br><br>The registered person did not ensure the proper and safe management of medicines in ensuring care and treatment was provided in a safe way for people.<br><br>Regulation 12(1)(2)(g) |

**The enforcement action we took:**
We have taken enforcement action and will report on this when complete.