Langdale View Limited

Langdale View

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

This inspection took place on 10 and 26 January 2018 and was unannounced.

Langdale View 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.

Langdale View provides nursing and personal care for up to 36 older people. Some of the people at the home are living with dementia. The home is located in Leicester and accommodation is provided over three floors with a lift for access. At the time of our inspection there were 35 people accommodated at the home.

The service had a registered manager. This 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 at the home because there were always staff on hand to support and care for them. Staff understood the importance of protecting people from harm including those who might not be able to say if something was wrong. If people were at risk due to their mental health or physical disabilities staff took action to minimise this.

Staff treated people with kindness and compassion. They valued people as individuals and were interested in them and their lives. The staff team was multicultural, reflective of the local area's rich cultural heritage, and had a positive approach to diversity. People's privacy, dignity and independence was respected and promoted.

People said the home had a happy and calm atmosphere. Staff said they enjoyed working there because they were able to get to know the people they supported as individuals and build up relationships with them. The staff were well-trained and knowledgeable about the needs of the people they were supporting.

There were enough staff employed to meet people's needs. Communal areas were well-staffed and if people were in their bedrooms staff regularly checked on them. Staff had time to assist people with their needs and also to socialise with them and support them to take part in activities. Staff were safely recruited in line with the providers' safe recruitment policies and procedures.

Medicines were stored securely and safely administered. People were protected by the prevention and control of infection. If any accidents or incidents occurred lessons were learnt and action taken to reduce risk in future.

People were supported to eat, drink and maintain a balanced diet. People had a choice of dishes, portions

were of a good size, and the food well-prepared. If people needed assistance with their meals staff provided this.

Care plans were personalised and gave clear information to staff about each person's specific needs and how they liked to be supported. People were satisfied with how their personal care was provided. Staff ensured people had regular access to GPs and other healthcare professionals as required. Staff understood the importance of people consenting to their care.

People were able to take part in activities of their choice. People had individual activity profiles setting out their hobbies, interests, and what activities they would like to take part in. Recent group and one-to-one activities had included baking, watercolour painting, visiting entertainers, board games, and coffee mornings run by a befriending service.

Surveys were used to gather the views of people, relatives and visiting professionals. The results of these showed a high level of satisfaction with the home. People, relatives and staff were also invited to share their views at one-to-one and group meetings with managers.

The providers and registered managers monitored the quality of the home and took action to bring about improvements where necessary. At the time of our inspection they were engaged in two projects run by a local university, one to improve outcomes for people living with dementia, and the other to reduce the risk of falls. These projects were an example of the continuous learning and improvement taking place at the home.

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.

There were systems in place to protect people from the risk of harm and staff were knowledgeable about these. Risks were managed and reviewed regularly to keep people safe from harm, injury and infection.

People were supported to take their medicines safely. Staff were committed to reviewing and learning from accidents and incidents.

Is the service effective?

Good

The service was effective.

People's needs were assessed and met by staff who were skilled and had completed the training they needed to provide effective care.

People were supported to maintain their health and well-being. Staff helped to ensure people's nutritional needs were met.

Is the service caring?

Good

The service was caring.

The staff were kind and compassionate and understood the importance of building good relationships with the people they supported.

People were involved in making decisions about their care and support. Staff supported people to be independent and to make choices. People's privacy and dignity was respected and their diverse needs met.

Is the service responsive?

Good

The service was responsive.

People were supported to be involved in the planning of their care. They were provided with support and information to make

decisions and choices about how their care was provided.

People knew how to complain if they needed to and had access to the service's complaints policy. Staff supported people at the end of their lives to ensure they were comfortable.

Is the service well-led?

Good

The service was well-led

There was clear leadership and management of the service which ensured staff received the support, knowledge and skills they needed to provide good care.

Feedback from people and staff was used to drive improvements and develop the service. People's diverse needs were recognised, respected and promoted.

Comprehensive audits were completed regularly at the service to review the quality of care provided. The service worked with other agencies to ensure people's needs were met.

Langdale View

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 providers are 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 was the service's first comprehensive inspection. It took place on 10 and 26 January 2018 and was unannounced. It was carried out by one inspector and, on the second day of the inspection, an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of service.

Prior to our inspection we received an anonymous concern about staffing at this home. We followed this up and were unable to find any evidence to support this concern.

We looked at information received from local authority and health authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided.

We reviewed the providers' statement of purpose and the notifications we had been sent. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about.

We spoke with nine people living in the home and five relatives. We observed people receiving care and support in communal areas. We also spoke with the providers, the two registered managers (one of whom was also the providers' operations manager), the deputy manager, the head of care, a staff nurse, three care workers and the providers' activity and well-being co-ordinator

We looked at four people's care records and 10 staff recruitment records. We looked at other information related to the running of the home including quality and safety audits, staff duty rotas, and meetings minutes.

Good

Is the service safe?

Our findings

People told us they felt safe at the home. One person said, "It is safe because there are always staff here to look after me. They are here in the lounge and if I'm in my room they come and see me to make sure I'm alright." Another person told us, "I think this is the safest I've ever been!"

Relatives said their family members were safe. One relative told us staff kept their family member safe by assisting them to get up from their chair and ensuring they used their walking aid. During our inspection people were relaxed, comfortable and safe. Staff were quick to provide support and reassurance when it was needed.

Staff were trained in safeguarding (protecting people from abuse) and understood the signs of abuse and how to report any concerns they might have. The providers' safeguarding policy told staff what to do if they had concerns about the welfare of any of the people they supported. Staff understood the importance of protecting people from abuse including those who might not be able to say if something was wrong. They knew the physical, emotional and other signs of abuse and who to report these to. One staff member said, "We have to speak up for people with dementia because they can't always speak up for themselves."

Managers ensured that staff remained focused on safeguarding by discussing it during staff meetings, handovers and one-to-one supervision sessions. For example, the minutes of the most recent staff meeting, held in October 2017, showed safeguarding was discussed and staff knowledge of the providers' safeguarding policies and the different types of abuse confirmed.

Records showed that if a safeguarding incident occurred staff took appropriate action. A referral was made to the local authority and the Care Quality Commission (CQC) notified of the incident. This meant that external agencies were aware of the incident and could take action as necessary to ensure people were safe.

Staff knew how to support people to remain safe. We saw them assisting people to move safely around the premises in wheelchairs. They ensured footplates were in the right position and used brakes to secure the chairs when they were stationary. If people had walking frames or other aids and adaptations staff ensured they were nearby to them if they were seated and gently reminded them to use them if they got up. We asked staff about how they supported specific people and they were able to tell as where each person was at risk and what they could do to minimise this.

We saw that some people liked to sit in the large entrance hall to the home rather than in one of the lounges. Staff said they preferred this area because it was busy and there was plenty of coming and going to observe. Staff ensured the people there were safe and comfortable and when visitors came and went there was always a staff member available to let them in and out of the building.

Records showed that people had risk assessments in place where necessary. These were linked to people's care plans so it was easy for staff to find the information they needed to support people safely. For example, one person who was at risk of falling had risk assessments in place for this. They stated the person needed

particular equipment to move and two staff to assist them. During our inspection we saw staff support them to leave the dining room and go to their room for a rest. This was done safely.

Another person was at risk of malnutrition and had come into the home at a low weight. Their risk assessment showed staff had arranged for the person to be assessed by a dietician and were following the dietician's advice. This was for the person to be frequently offered healthy and fortified snacks. During the inspection we saw this person enjoy a wide range of snacks and drinks throughout the day as well as their regular meals. Records showed they had gained weight since coming to the home so the risk assessment and resulting care plan had been effective in keeping them safe for the risk of malnutrition.

Risk assessments addressed people's diverse needs. For example, one person's stated they were only to have female staff for their personal care as male staff might cause them to become distressed. Risk assessments were reviewed at least monthly and updated as necessary if people's needs changed. All the people living in the home had PEEP's (personal emergency evacuation plans) in place so staff could assist them to safely evacuate the building in the case of an emergency.

People told us the service employed enough staff to meet their needs. One person said, "There are staff everywhere you go here. They are always looking after us." Another person commented, "There's plenty of staff. I've never had a problem with there not being enough of them."

During our inspection we saw that communal areas were well-staffed and people did not have to wait long if they needed staff support. Call bells were answered promptly. If people were in their bedrooms staff regularly checked on them to make sure they were safe. Staff had time to assist people with their needs and also to socialise with them and support them to take part in activities. Staff rotas showed good levels of staffing consistent with what we found when we inspected.

We checked staff files to see if those employed had been safely recruited and had the required documentation in place to demonstrate this. Staff files were well-organised with a 'checklist' at the front to show what they contained. All the staff files we looked at had the required documentation in place and showed that the providers had used safe and thorough recruitment methods when employing staff to work at the service.

The providers had safe recruitment policies and procedures in place and sources of reference, including the Home Office's 'An employers guide to acceptable right to work documents', to help ensure they recruited suitable staff who had the correct documentation. Staff files were audited regularly by management to check the required documentation was in place to demonstrate staff were suitable for their roles.

Staff were trained in the proper and safe use of medicines. One of the nurses told us she had been trained in-house and by the service's pharmacist. She said she had six monthly competence checks with one of the registered managers and felt competent and confident to give out medicines safely.

People's medicines were managed and administered safely A relative told us they were satisfied their family member received their medicines as prescribed. They said, "I'm okay with how they manage the medication. It seems to be given okay.''

People had personalised medicines care plans so staff knew how to administer their medicines in the way they wanted. For example, one person's stressed the importance of staff introducing themselves before offering the person their medicines as the person had sensory issues and would not necessarily know who had approached them. Another person had two medicines care plans, one for when they were willing to

take their medicines and one for if they refused. This meant staff would know what to do in either eventuality.

Medicines were stored safely and securely. Room and fridge temperatures were recorded daily to show they were within safe limits. MARs (medicines administration records) were in good order and completed in full. Each had a photograph of the person in question attached so staff could easily identify who the medicines belonged to, and also allergy information where relevant. Medicines prescribed on an 'as and when required' basis had accompanying protocols in place so staff knew when they should be administered and why.

Records showed the registered managers carried out routine medicines audits. The service's contract pharmacist had carried out an unannounced audit in October 2017. This showed the staff were managing medicines safely with 100% compliance in some key areas. Staff said they could contact the home's pharmacist for advice if they had any queries about the safety people's medicines.

People were protected by the prevention and control of infection. At the time of our inspection one of the registered managers, who was also the home's infection control lead, had attended a health service forum infection control training and discussion day. They had since updated and implemented the home's infection control policies and procedures.

Staff were trained in infection control and had updates at staff meetings to give them a better understanding of why infections happen. The registered managers had introduced an infection control log so staff could monitor infections to better understand what caused them and how they could be prevented. Increasing people's hydration, changing catheters as soon as there was any sign of infection, high standards of hygiene, and the use of long-term antibiotics for some people who were prone to infection had resulted in a reduction in infections at the home. Records confirmed this. It was evident that the registered managers and staff had worked hard to address this issue with the result that people in the home were now safer from the risk of infection.

If people were involved in any accidents or incidents staff kept detailed records and informed the relevant authorities included the local authority and CQC. Accident and incident records were audited to identify if there were any patterns or trends that needed addressing. Records showed that following accidents or incidents staff took action to help reduce risk. For example, a person had recently left the home unaccompanied when it was not safe for them to do so. In response the registered managers reviewed security and issued an instruction that only staff could let visitors and people in an out of the building. This improved safety and reduced the likelihood of a similar incident occurring.

Good

Is the service effective?

Our findings

Senior staff members assessed people's care needs before they came to Langdale View. This was to ensure their needs could be met at the home. The assessment covered the person's health and medical background as well as their emotional and social support needs. The information gathered was used to produce a plan of care that was reviewed and updated as staff got to know the person.

The ten-page assessment document was comprehensive but in need of some improvement in the way questions were asked. For example, under 'Nutrition – food and drink', the staff member completing the form had to answer yes or no to the question 'Takes a normal diet'. However it was not made clear what a 'normal diet' was. Improvements were also needed to how people's cultural needs were assessed.

People were asked for their 'Religious beliefs', 'First language' and 'Ethnic origin' but there was no information on how these, or any other cultural factors, might lead to particular support needs, for example in relation to diet, language preferences, or daily routines. However when we talked with staff they were aware of people's cultural needs so their was no negative impact on people at the time of our inspection. We discussed the assessment document with the operations manager who said it would be reviewed and improved so that in future there would be a written record of people's cultural needs and how staff would meet these.

People and relatives told us the staff were well-trained and knew how to provide effective care and support. One person said, "The staff know how to look after me. I don't have to tell them what to do." A family member told us, "[My family member] has to be hoisted in and out of bed now and that's done okay.''

Staff were knowledgeable about the needs of the people they were supporting. They received the training they required to provide good quality care and support to the people living in the home. One member of staff said, "We've all got National Vocational Qualification level 2 or above in Care. The training is good and it is always being updated."

Records showed that all staff completed a comprehensive induction followed by a range of training courses designed to equip them with the skills and knowledge they needed to meet the needs of the people living in the home. Training was provided in-house and by external trainers, including those employed by the local authority and the health authority. This ensured staff had a range of different training opportunities and trainers. Staff had recently attended courses on infection control, health and safety, and positive behaviour support (a person-centred approach to people who display or are at risk of displaying behaviours which challenge).

People were supported to eat, drink and maintain a balanced diet. They said they enjoyed their meals. One person said, "There's a reasonable amount of variety and some choice.'' A relative told us, "The food is good. [Person] has a nice breakfast usually weetabix and toast and there's homemade jam. There's a good choice for lunch.''

We saw lunch being served on one day of our inspection. The menu consisted of fish with chips or mashed potatoes or vegetarian lasagne. One person told us they were having sausage and mash as they didn't like fish or lasagne. Staff told us that although there was a set menu with choices people could always have something else if they preferred. There was music playing quietly in the dining room and there was a relaxed atmosphere. Portions were of a good size and well-prepared. People were offered a choice of drinks.

People had care plans for their nutrition and hydration so staff knew how to meet their needs. For example, one person came to the home 'at a low weight and with a poor dietary intake'. Staff took action referring the person to a dietician and providing them with fortified meals. When we inspected their care plan it instructed staff to weigh the person weekly and complete food charts so they could monitor how much the person was eating. Records showed staff were doing this and working in conjunction with the dietician to improve the person's dietary intake.

People's likes and dislikes and the support they needed at mealtimes was recorded in their care plans. For example, one person's stated, 'Staff to remind [person] about mealtimes and assist [person] with their food where necessary.' It also stated, '[Person] likes to have their cup of tea not too sweet with some biscuits near [another person living in the home] for company.' These instructions helped to ensure staff provided this person with effective support with their nutrition and hydration.

People had regular access to a range of healthcare professionals including GPs, district nurses, OTs (occupational therapists), and others as required. People's care plans showed that staff were following advice from health and social care professionals and contacted them where necessary if people's needs changed. A relative told us, ''Staff are more than adequate. They are very good at getting GPs out when needed. They acted promptly when [my family member] had an adverse reaction to some antibiotics.''

If people needed specialist support staff organised this for them. For example, staff had referred a person to a specialist dementia care team who were providing staff with advice on how best to support the person to settle at the home.

The premises had been adapted and improved to meet people's diverse needs. There was a lift for access to the first and second floors and a ramp to one communal area to make it easier for people with limited mobility to get around. Toilets and bathrooms had signs on the doors to make the purpose of the rooms clear. There were large murals of landscapes and an old fashioned sweet shop in communal areas and a fish tank in the entrance hall. This created a more interesting environment for people. At the back of the home was a secluded courtyard which staff said people liked to use in warmer weather. People were provided with appropriate equipment to ensure their needs were met including walking and standing aids, hoists, and pressure relief mattresses and cushions

People were encouraged to make decisions about their care and their day-to-day routines and preferences. Care plans set out how people best communicated their choices and if, on occasions, they might not be able to do this. For example, one care plan stated, 'I can verbally communicate but on occasions this might not be reliable due to early dementia.' This helped to ensure staff had the information they needed to support people to determine their own lifestyles.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The requirements of the MCA were being followed. When people were not able to make some decisions for themselves, mental capacity assessments and best interest decisions were made. When people were being restricted, DoLS applications had been made and were being monitored by the DoLS team.

Staff were trained in the MCA and DoLS and understood the importance of people consenting to their care and what to do if it appeared they were not able to do this safely. The operations manager told us the providers had recently appointed a MCA consultant to provide further and more intensive training for staff and advice on MCA issues.

Good

Is the service caring?

Our findings

Staff treated people with kindness and compassion. People told us they got on well with the staff. One person said, "They [the staff] are caring and try to spend time with you. There is one who is very jovial which is good.'' Another person commented, "It's nice here. I feel comfortable with everyone.''

People were valued as individuals and staff were interested in them and their lives. Each person had a 'map of life' in their care records which staff used to learn about them, their histories, and their likes and dislikes. One person had a background in business and enjoyed helping staff with office tasks. Staff said this gave the person a sense of purpose. This was an example of staff taking a personalised approach in providing a person with care, support and fulfilment.

We met another person who was smartly dressed in coordinated clothing. They told us, "Being well turned out is very important to me. They look after me and help me sort out my clothes very well.'' This was a further example of staff understanding what was important to a person and supporting them to achieve the lifestyle they wanted.

The home celebrated diversity. Staff understood people's cultural needs and these were documented in their care plans. The staff team was multicultural, reflective of the local area's rich cultural heritage, and had a positive approach to diversity. We heard staff discussing a forthcoming cultural event with one person who was looking forward to this as it concerned their country of origin.

Staff had good relationships with the people they supported and interacted with them in a warm and caring manner. If people had communication needs staff were aware of these and communicated with them appropriately using touch and other body language. We observed that people were relaxed in the company of staff and accepted reassurance from them when necessary.

Staff involved their own families in socialising with people. For example, staff arranged a trip to Skegness taking their own children and three people living in the home with them. The operations manager told us the people who went said they liked taking part in a family outing and particularly enjoyed watching the children who joined the trip have fun at the seaside.

People, who were able to, were involved in planning and reviewing their care. Where people lacked the capacity to make some decisions for themselves, staff involved relatives in writing and reviewing care plans. One relative told us, "There is a care plan for [person]. Another family member deals with it but the home has always kept us up to date.''

Relatives said staff always contacted them if there were any issues about their family member's care. One relative told us, ''They are very good at telephoning one of us with updates on [the person's] condition etc. This is very good and helps us."

People's privacy, dignity and independence was respected and promoted. All staff were had signed up to be

'dignity champions' meaning they had made a pledge to challenge poor care, act as good role models, and were committed to providing people with compassionate and respectful care and support.

During our inspection we saw staff were always polite and respectful towards people and provided them with discreet support when they needed it. There were signs on people's bedroom doors reminding staff and visitors to knock before entering. One person said, "The staff never just come into my room. They always tap on the door and ask first."

Good

Is the service responsive?

Our findings

Care plans were personalised and gave clear information to staff about each person's specific needs and how they liked to be supported. They were reviewed monthly or as people's needs changed. Care plans gave guidance to staff on how people wanted their care provided. For example, one person's stated, "I like to go to bed early and the staff do help me to do that." People said they were satisfied with how their personal care was provided. One person told us, "I'm quite comfortable and my needs are met. I'm fine with the personal care."

We looked at how people's care and support was planned. One person was admitted with 'fragile skin' and needed support to prevent any damage. Their care plan for this put a range of measures in place to help keep the persons skin intact. One of these was to 'encourage fluids to keep skin hydrated'. We saw this person a number of times during our inspection and they always had fresh cups of juice and tea next to them which they were seen drinking. Fluid charts showed the person's intake was measured to ensure they had the hydration they needed.

Another person had communication needs. Their care plan set out how staff should interact with them stating, 'I would like you to approach me slowly, maintain eye contact and speak to me in clear, simple terms enabling me to answer yes or no.' Staff were also told to give the person the opportunity to consider what had been said to them and allow them to reply in their own time. The staff we spoke with were aware of this guidance and knew how to approach this person in a sensitive and empathetic way in order to provide them with responsive care and support.

People were able to take part in activities of their choice. At the time of our inspection the home had just recruited a new activities coordinator. Until they started work a member of the care staff team was overseeing the activities programme.

Each person had individual activity profile setting out their hobbies, interests, what activities they would like to take part in, along with their life history so staff could get an idea of activities they might like to try. The activities log book showed that recent group and one-to-one activities had included baking, watercolour painting, visiting entertainers, board games, and coffee mornings run by a befriending service. One person told us, "We play dominoes and Jenga which is good, but I'd like a bit more variation.'' The operations manager told us once the new activities coordinator started work the programme of activities would increase.

People had access to the information they needed in a way they could understand it in order to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place in 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. At Langdale View the service user guide and statement of purpose were available in large print and different languages on request. Staff knew people well and were aware of their communication needs and the best way to support them with access to information.

People and their families were given information about how to complain and details of the complaints procedure were displayed in the home. People told us they knew how to raise a concern and they would be comfortable doing so. One person said, "If I had a problem I could speak to staff or [one of the registered managers]." People were also given the opportunity to raise formal or informal concerns and complaints on a one-to-one basis or at care reviews and meetings.

We looked at how people's concerns and complaints had been listened and responded to. The home had received two informal complaints since we last inspected. In each case the complaint had been recorded along with the action taken to resolve it and, where necessary, bring about improvements to people's care and support. For example, one complaint concerned a person's hearing aid not working due to the batteries failing. To prevent this happening again staff were told to check the batteries daily to ensure they were working and sign a form to say they had done this. This showed the complaint had been addressed and action taken to improve the support the person had with their hearing aid.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Staff worked closely with healthcare professionals to ensure people had the care and support they needed. We looked at one person's end of life care plan. This was personalised. It took into account that the person did not always have the mental capacity to tell staff the kind of care they wanted, so staff liaised with the person's family member where necessary. The care plan also stated that the person did not have verbal communication skills so staff needed to monitor non-verbal signs to check that the person was not in any pain. This was an example of staff understanding a person's needs and providing for them in a sensitive and responsive way.

Good

Is the service well-led?

Our findings

People told us they liked living in the home which they said had a happy and calm atmosphere. One person told us, "It's nice and quiet and the staff are kind." Another person told us, "Everybody's happy here. The staff and the residents." A relative said, "It's a lovely care home. The staff have been lovely and I would recommend it.''

Staff said they would recommend the home to their own family members if they needed care and support. They told us they enjoyed working at the home because they were able to get to know the people they supported as individuals and build up relationships with them. One staff member told us, "It's all about the residents here and what's best for them." Another staff member said, "We let the residents do what they want as long as it's safe. The home is not an institution and the residents are encouraged to be themselves."

The providers and registered managers and staff monitored the quality of the home and understood and managed risks and regulatory requirements. Their audit system centred on the registered managers' monthly quality assurance audits which covered all aspects of the home. Records showed the audits were robust and action was taken to bring about improvement where necessary.

The registered managers had carried out surveys to get people's and relative's views on how it was running. The majority of the nine respondents said they were satisfied with all aspects of the home. Relatives wrote of the 'warm welcome' they received when they visited and how well their family members were looked after and cared for. One relative commented on how personalised the home was in that staff knew their family member's professional background and ensured they were always smartly dressed in keeping with their preferences.

Five visiting professionals had also completed surveys. All said they were made welcome, the information they needed was forthcoming, the objective of their visit fulfilled, and people's health and social care needs met. Comments included: 'staff friendly and helpful when I visit' and 'staff open in discussions about service users'. The registered managers kept a book of compliments and thank you cards that were available for people and visitors to see and provided further evidence that people were receiving a good-quality service.

Regular residents meetings were held to provide people with a further opportunity to share their views. The minutes of the last meeting, held in December 2017, showed that activities were discussed as was a forthcoming charity fun day. The minutes did not have the names of the people who attended on it so it was not possible to see how many people attended the meeting. The registered managers said this information would be included on future minutes so it was clear how effective residents meetings were in obtaining feedback from people.

Staff meetings were also held regularly and action taken in response to staff suggestions and feedback. For example, at the last staff meeting in October 2017, staff asked for a second hoist to be provided for use on the second floor of the premises so there was no delay when people wanted to get up. The providers supplied this hoist which showed that staff were listened to.

Staff told us the providers and managers were supportive of them. The deputy manager said, "We [the staff] are a team. We plan everything together. The managers do shifts. They covered new year's eve so some of the staff could have a night off." Staff had regular supervisions, appraisals and meetings to reflect on their work, discuss their training needs, and comment on the home. Staff turnover and sickness levels were low which meant people had continuity of care. Staff members' work was recognised in monthly awards where staff who had made outstanding contributions to the home were presented with certificates and vouchers. This was evidence of staff being valued at the home.

The providers, registered managers and staff worked to improve the home and introduce new ways to enhance people's quality of life. At the time of our inspection the focus was on outcomes for people living with dementia. We met with the providers' activity and well-being co-ordinator who was involved in an enrichment project run by a local university. The purpose of the project was to introduce new activities to people living with dementia including music therapy. When we inspected the activity and well-being co-ordinator was developing this programme at Langdale View in conjunction with care and support staff.

The home was also taking part in a falls-reduction research programme at the same university. The registered managers told us this had led to improved staff training in falls-reduction and the introduction of a falls action plan to be used with people at high risk of falling. The home had also adopted new 'best interests' end of life care plans to help ensure the right decisions were made for people assessed as lacking mental capacity. These projects and initiatives were examples of the continuous learning and improvement taking place at the home.

The home worked in partnership with other health and social care professionals such as district nurses, GPs, and social workers. Referrals had been made to relevant professionals when required. The registered managers had also established links with health and social care commissioners and sourced training, attended meetings, and taken advice from them to help ensure they were meeting their contractual obligations to provide a safe and well-led home.

The providers and registered managers have a legal duty to inform the CQC about certain changes or events that occur at the home. There are required timescales for making these notifications. We had received notifications as required and saw from these that appropriate actions had been taken following accidents and incidents at the home.