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Langdale Heights

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 31 May 2016. We returned announced on the 3 June 2016 to complete our inspection.

Langdale Heights has 31 beds and provides residential and nursing care to older people, some of whom are living with dementia and/or physical disabilities. It is has 27 single rooms and two double rooms. At the time of our inspection there were 25 people using the service.

The service has 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 using the service told us they had not always felt safe at Langdale Heights. Staff had failed to follow the providers' safeguarding procedures and had not always reported safeguarding incidents to the relevant authorities. People did not always have appropriate risk assessments in place to help ensure they remained safe at the service.

During our inspection visits there were sufficient staff on duty to support the people using the service in a timely manner. However, some people felt there was a delay in personal care being provided on occasions.

Staff were safely recruited. Staff training had not always been effective and there were gaps in the providers' staff training programme and supervision schedule.

People using the service told us they were satisfied with the food provided. People had a choice of dishes at each meal. The food served was well-presented and looked appetising. If people needed assistance with their meals staff provided this on a one-to-one basis.

People had access to a range of healthcare professionals including the nurses employed, GPs, mental health practitioners, district nurses, chiropodists, opticians, and dentists. However people had not always been referred to the appropriate healthcare services for treatment and people's healthcare needs had not always been planned for. Medicines were safely managed and administered in the way people wanted them.

People using the service and relatives told us the staff were caring and kind. We observed that staff spent time sitting and talking with people. We heard them speaking kindly to people while they supported them and reassuring people when they needed this. Improvements were needed to how people were supported to express their views and to how their privacy and dignity was maintained.

People's needs were assessed prior to them coming to the service but these had not always been taken into account when staff planned their care and support. Some activities were provided at the service but people

said they would like a wider range of activities to choose from.

Some equipment and areas of the premises were in need of a deep clean and we found issues with health and safety at the premises. Improvements were needed to the way the registered persons implemented the Mental Capacity Act 2005. This was because staff were unclear as to the criteria for referring people to the Deprivation of Liberty Safeguards team.

When we carried out our first inspection visit the registered manager was not at the service. People using the service and staff told us they were unsure about whether she was still working there. On our second inspection the registered manager was back full-time at the service.

Between our two inspection visits, and in response to the concerns we raised, the providers carried out a number of improvements to the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People using the service told us they had not always felt safe recently. Some safeguarding incidents had not been reported to the local authority in line with the providers' policy, however actions had since been taken to address this. Staff did not have all the information they needed to manage risks at the service. There were enough staff on duty to meet people's needs. Medicines were safely managed and administered in the way people wanted them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not always had the training they needed to effectively support the people using the service. Improvements were needed to the way the registered persons implemented the Mental Capacity Act 2005. People were supported to have sufficient to eat, drink and maintain a balanced diet. One person had not been assisted to access healthcare services when they needed to.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were caring and kind. Improvements were needed to the way people were supported to make choices about their lives and to how their privacy and dignity was maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care was not always planned and delivered in accordance with people's preferences and to meet their needs. Activities were available and in the process of being improved. People knew how to make a complaint if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a lack of clarity about who was in day to day charge of the service. People using the service and staff had not always been given the opportunity to share their views about the service. Management systems were ineffective and had not always identified shortfalls in service provision.

Langdale Heights

Detailed findings

Background to this inspection

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

This inspection took place on 31 May 2016 (unannounced) and 3 June 2016 (announced).

For our first inspection visit the inspection team consisted of one inspector, a specialist advisor, and an expert by experience. A specialist adviser is a person with professional expertise in care and nursing. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. For our second inspection visit the inspection team consisted of one inspector and a specialist advisor.

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

We also reviewed the provider's 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 used a variety of methods to inspect the service. We spoke with seven people using the service, three relatives, and a visiting healthcare professional. We also spoke with the registered manager, operations manager, the providers, two registered nurses, the activity coordinator, and four care workers.

We observed people being supported in communal areas. We looked at records relating to all aspects of the service including care, staffing and quality assurance. We also looked in detail at six people's care records.

Requires Improvement

Is the service safe?

Our findings

During our first inspection visit some of the people using the service told us they felt safe at Langdale Heights. One person said, "It feels safe", and another person commented, "It's alright here, I feel safe."

However one person using the service said that although they usually felt safe they were concerned about an incident that had occurred the previous day when another person using the service "went on the rampage" and staff called the police to the service. The person told us they had seen the distressed person "grabbing hold of other residents and staff" and was concerned that someone might be injured if a similar incident occurred. Another person also referred to the incident. They said that in their opinion staff had lost control and they had been afraid that they themselves might be assaulted by the person.

Records showed this was not an isolated incident and that over the four weeks prior to our inspection visits a number of similar incidents had occurred involving the same person. These included assaults on people using the service and assaults on staff. Records stated that staff had used restraint on occasions even though they were not trained or authorised to do this.

None of these incidents had been reported to the local authority safeguarding team or to CQC. This meant staff had not followed the providers' safeguarding procedure which stated that safeguarding incidents must be reported to the local authority and CQC informed.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment. The registered persons had not ensured that people using the service had been protected from abuse and that their systems and processes to prevent and investigate abuse had been followed.

We discussed this with the provider's operations manager. They told us that they had contacted the person's social worker to report their concerns. However they had not informed the local authority safeguarding team or CQC of the safeguarding incidents that had occurred at the service.

Following the first day of our inspection visit CQC informed the local authority of these incidents. When we returned to the service for the second day of our inspection visit the person no longer lived at Langdale Heights.

The provider told us that in the time this person had been at the service staff had worked with mental health and social work specialists and GPs with a view to supporting this person to stay at Langdale Heights. However they had come to the conclusion that the person's needs were too complex and could not be met at Langdale Heights.

We reviewed this person's care records and found that they did not have appropriate risk assessments in place to protect them and other people at the service from harm. We found that on admission this person had a history of verbal and physical aggression towards staff and other people using services. However,

there was no risk assessment for this and limited information or guidance for staff in care plans in how to support this person.

For example, the person's care plan for 'behaviour that challenges' described how the person might behave and told staff to 'record and report any challenging behaviour'. The latest review of this care plan told staff to 'be calm and assure [the person] he is safe and [the staff] will soon understand what [the person] is trying to tell us'. It was not clear what this meant and there was no further information or guidance for staff.

This meant staff did not have clear instructions on how to support this person safely if they became distressed. Daily care records showed that staff had tried to reassure this person on a number of occasions but this hadn't always worked and the person had become physically aggressive. There were no instructions in care records telling staff what to do if this happened which may have been the reason staff resorted to using unauthorised restraint.

Another person's care records stated they were 'at risk of injuries and as well at risk of experiencing high levels of anxiety when [person] hides in the wardrobe'. They did have a risk assessment for this which stated 'Staff to be aware of [person's] attempt to hide in the wardrobe and to be the first point to search for [person]. Ensure that wardrobe is securely fixed to the wall.' We checked the wardrobe and it was bolted to the wall. However it had torn up plastic aprons inside it which could present a risk to a person using the service.

The same person was identified as being at risk of self injury due to taking the paint off the wall next to their bed with their fingernails. Care records stated, 'Staff to approach [person] calmly and to explain the risk [person] exposes themselves to, however if [person] continues to display this behaviour staff to check fingernails and to offer first aid.'

In each of these care records there was no analysis on the possible causes of these behaviours, nor information for staff on what to do to prevent them occurring. This meant staff did not have the information they needed to support these people in the event of them engaging in behaviours that might harm them or others around them.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. The registered persons had not done all that was reasonably practicable to minimise the risks to the health and safety of the people using the service.

We talked with people and relatives about staffing levels at the service and got mixed responses. One person using the service told us, "The care's alright but there are not enough staff, you have to wait." They went on to tell us, "I'm late getting up sometimes, staff shortages all the time, it's often a problem. I have to wait at nights and weekends." A relative said, "I think they're pushed sometimes, I see and hear people waiting for the toilet." Two other relatives said they thought the staffing levels were acceptable. They told us, "Yes people sometimes have to wait, but not for long. We've never seen this be a problem."

We spoke with four care workers about staffing levels at the service. All said they thought they were acceptable. One care worker said, "We're busy but we can manage." Another care worker said, "I think the staffing levels are OK. We have time to sit and talk to the residents."

During our inspection visits we observed there were sufficient staff on duty to support the people using the service in a timely manner. We discussed staffing levels with the registered manager. She told us she used a 'service users dependency tool' to calculate how many staff were needed for each shift. She told us staffing

levels were reviewed on a daily basis and this would continue to ensure there were sufficient numbers of staff on duty at all times to keep people safe and meet their needs.

A recruitment and selection process helped ensure the staff recruited had the right skills and experience to support people using the service. We looked at three staff recruitment files which showed recruitment checks were completed before new staff started working in the service. Files included a Disclosure and Barring Service (DBS) check and appropriate references. The DBS checks help employers to make safer recruitment decisions and prevent unsuitable people from working with people using the service.

People using the service told us they were given their medicines when they needed them and a relative told us their family member received his medicines on time.

Medicines were kept securely in a designated treatment room. Records showed that people using the service had plans of care in place for their medicines to be administered safely. These included information on how they liked to take their medicines, what they were for, and any side-effects they and the staff needed to look out for. If there were concerns about a person's medicines they were referred to their GP for a review.

We observed two medicine rounds during our inspection visits. We saw that two registered nurses dispensed medicines to individual people using the service from a locked facility in the treatment room. The treatment room door was also locked each time it was left unoccupied. This helped to ensure that medicines were kept secure. Records showed that staff who administered medicines were trained to do this and their medicines training was renewed every three years.

One person using the service had a medicines patch prescribed for them, this was changed daily. However there was no patch chart to record positioning of the patch on the body in order to prevent local irritation, or that the medicines remained effective if the same area was used too frequently. The registered nurse in charge told us she was aware of patch body charts and would ensure one was put in place.

Relatives told us they had no concerns about the cleanliness of the premises. During our first inspection visit we found the premises to be mostly clean and fresh and staff attended promptly to a spillage in the conservatory. However some equipment and some specific areas of the premises were in need of a deep clean. For example, we found a stand aid hoist in a poor state of cleanliness. Some skirting boards were dirty, as were some ensuite toilets and shower rooms. We reported these issues to the providers.

When we returned to the service for our second inspection visit we found improvements to the cleanliness of the equipment and premises had been made. All moving and handling equipment had been deep cleaned, as had areas of the premises in need of this. The registered manager told us she was putting a new cleaning schedule in place and would carry out daily inspections of the equipment and premises to ensure they were of a good standard of cleanness.

During our first inspection visit we also found some issues with health and safety at the premises. In one bedroom an extension lead was hanging below a wall-mounted television set. This could present a risk if a person became caught in the lead. In another bedroom a person's bed was against a wall next to a bank of four plug sockets. These were level with the bed and could present a risk as the plug sockets were within hands reach. There were also inconsistencies regarding the risks associated with two sets of stairs at the premises. One had a locked gate at the top and a stair alarm at the bottom. The other had stair alarms at the top and bottom. However, whilst we were in the building the alarms were turned off so it was unclear if this arrangement was safe.

We reported these issues to the providers. While we were still in the building they called an electrician who arrived at the service to assess the safety of electrical equipment. When we returned for our second inspection visit the electrical equipment had been made safe, the stair alarms were on, and the registered manager told us she was in the process of carrying out a risk assessment of the premises. This was evidence that the providers had taken action to improve safety at the service.

Requires Improvement

Is the service effective?

Our findings

People using the service told us they thought staff were well-trained. One person said, "They know how to support me." Another person told us, "[The] staff know what they're doing." They added that they had seen new care workers getting support from more experienced staff. A relative said, "As far as you can tell the staff are well trained."

We looked at the providers' training matrix which listed the courses staff had completed. This showed that most staff had been trained in key areas, for example health and safety, moving and handling, communication, and person-centred care. However there were some gaps in staff training. The operations manager said the providers had a rolling training programme and that all staff would eventually have the training they needed.

We could not be sure that training had always been effective. For example, records showed that staff had undertaken training in safeguarding and the staff we spoke with told us they knew that safeguarding incidents needed to be reported to the local authority. However in the weeks prior to our inspection visits a number of serious safeguarding incidents had occurred and these had not been reported. There were also gaps in the programme of staff supervision sessions which meant that opportunities for staff to discuss and reflect on their training may have been missed.

We also saw in care records that staff had used restraint on a person using the service. One care worker told "I've not had training in breakaway techniques. I've had training in challenging behaviour. I used common sense. I just held [the person using the service] gently." Without the proper training and authorisation the use of restraint could put the people using the service and staff members at risk.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing. The registered persons had not ensured that staff employed by the service had received the appropriate support and training to enable them to carry out the duties they were employed to perform. When we discussed this with the providers who told us that prior to our inspection the need for 'breakaway' training had already been identified. They told us this had been booked and was due to take place after our inspection.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

During our inspection visits we saw staff offering people choice and asking their permission before providing them with care and nursing. For example, we saw one staff member asked a person if they would like some personal care. The person declined so staff said they would come back later and ask the person again. They did this and the person consented to have their needs met. This was a positive example of staff offering people a choice as to when they would like their support provided.

Staff at the service had some understanding of the MCA and DoLS and some people using the service had DoLS authorisations in place due to restrictions on their liberty. However it was unclear why some people had been referred to the DoLS team and others, who might benefit from this, had not.

The registered manager told us she was in the process referring everyone with a diagnosis of dementia to the DoLS team first as this was what she thought was required of her. However, having a diagnosis of dementia does not automatically mean a person lacks mental capacity. We discussed this with the registered manager who agreed to seek further advice from the DoLS team.

Following out inspection visits the registered manager wrote to us to tell us that she had sought advice from the DoLS team and was acting on it with regard to who was referred. This will help to ensure that consent to care and treatment is sought in line with legislation and guidance.

People using the service told us the food provided was satisfactory. One person said, "I like everything, you get a choice." Other people commented: 'the food's okay; 'I like the food'; and 'the food's not bad, I like good food'. Drinks were offered to people at intervals during the day and people told us they had enough to eat and drink.

We observed lunch being served. People were given the choice of having their meal in the dining room or in the lounge. The food served was well-presented and looked appetising. Food was prepared in the way that appropriate for people, for example in a pureed form if required. If people needed assistance with their meals staff provided this on a one-to-one basis.

Care records, including weight audits and nutritional reviews, showed that staff monitored people's nutrition and hydration and took action if they needed extra support. For example, people were referred to their GPs and to dieticians and some people were put on fortified diets with food and fluid charts put in place to monitor their progress. During our inspection people were regularly offered meals, snacks and drinks. This showed that staff helped to ensure people were supported to eat and drink enough and maintain a balanced diet.

People told us that if they needed to see a GP or other healthcare professionals, staff organised this for them. One person said they had seen a chiropodist and an optician at the service. Another person commented, "I get to see the GP if needed. It's quite quick."

Care records showed that people had access to a range of healthcare professionals including GPs, mental health practitioners, district nurses, chiropodists, opticians, and dentists. If staff were concerned about a person's health they discussed it with them and their relatives, where appropriate, and accompanied them to appointments if necessary.

Records showed that people had not always been referred to the appropriate healthcare services for treatment. One person, who was having residential care (as opposed to nursing care) at the service, had developed a pressure wound. Rather than follow protocol and refer this person to the local district nursing team, nursing staff at the service had initially treated the wound themselves. This meant there was a delay in

the district nursing team being made aware that this person needed treatment from them.

When we discussed this person's treatment with staff they were unable to inform us of the extent of the wound as they left it for the district nurses. If care workers are not kept fully informed moving and handling and positioning of the person could compromise the healing process.

This was an example of staff not being fully aware of a person's healthcare needs. We discussed this with the registered manager. She said she would address them through staff training and supervision, and improved care plans.

Requires Improvement

Is the service caring?

Our findings

All the people using the service and relatives we spoke with said the staff were caring and kind. One person told us, "The staff are very good, caring, I feel comfy with the staff." Another person commented, "The staff are caring, I like most of them."

A relative told us they had confidence in the staff and told us, "They are lovely, caring, and always speak." They said that one of the nurses was particularly good and would phone to update them on their family member's progress. Other comments from relatives included: "I see care staff sitting and chatting to people"; "The staff are lovely, caring, [and] always speak"; and, "The staff are wonderful. They never get angry. They deal with [my family member] with patience."

We observed staff spent time sitting and talking with the people using the service. We heard them speak kindly to people while they supported them. We saw one staff member communicate warmly with a person who appreciated this and told us how much they liked this staff member. They told us, "He's a good boy (staff member) he's very good to me." We saw another staff member comforted a person who was distressed. The staff member was compassionate towards this person and asked them if they needed 'a cuddle'. The person responded positively to this.

One person told us they had control over their wishes. They told us they could 'more or less get up and go to bed when I want'. Another person said , "I can do what I want [at the service]." A relative said they were involved in their family member's care. They said they had attended specific meetings about their family member's needs and was involved in care planning.

People told us they felt they were treated with respect and their privacy and dignity was maintained. There was a display about dignity on one wall in the dining room so people could see what their rights were. One person said, "Staff do knock on the door, but then probably come straight in." Another person told us "privacy and dignity is okay mainly."

Improvements were needed to how people were supported to express their views. During the morning we saw a member of staff asking people what they wanted for lunch from a choice of two main courses. It would have been helpful if staff had used photos of the meals to make the experience more inclusive for people with limited verbal communication skills.

There was a board up in the dining room which displayed the four-weekly menus. This densely-typed document was not accessible to some of the people using the service. This was because they had difficulty with the written word, or simply because you needed to stand close to the list to read it and many people were not independently mobile enough to do this. There were some pictures of typical meals but they were not of anything that was being offered for lunch that day. Making information about the menu more accessible and user-friendly would help ensure that people had choices about what they wanted to eat.

Improvements were needed to how people's privacy and dignity was maintained. We saw two double

occupancy bedrooms. On the first day of our inspection visit we found that neither had a working curtain or any other type of room divider in place to enable people to be supported with their personal care in private. We brought this to the attention of the registered persons. When we returned for the second day of our inspection visit this issue had been addressed and new curtain rails and curtains were in place.

On the first day of our inspection visit we found that one person's bedroom was being used to store three wheelchairs during the day. We brought this to the attention of a staff member who removed the wheelchairs and said they should not have been left in a person's private space. On the second day of our inspection visit we found wheelchairs had been appropriately stored in designated areas.

On the first day of our inspection visit we found that none of the bedroom doors had locks on them so people who were able to could not secure their rooms if they wanted to. We discussed this with the registered persons who agreed that people should have the option of having lockable bedrooms. When we returned for the second day of our inspection visit the registered manager was in the process of asking everyone using the service whether they wanted locks of their doors. She said she had already spoken with three people and one of these said they wanted a lock. The registered manager said that where people wanted locks, these would be fitted in the next few weeks.

On the first day of our inspection visit we met with one person using the service whose personal care was of a poor standard. The person had dried food on their face, what looked like skin flakes on their clothes, and evidence of body odour and poor oral hygiene. We reported this to staff who told us this person sometimes resisted personal care. We discussed this with the registered manager who said she would review the person's care plan to ensure that staff were doing all they could to support the person with their personal care. When we returned for our second inspection visit this person's hygiene had improved and they were in clean clothes

We discussed these issues with the registered manager who said that now she was back at the service permanently she would be able to monitor this to ensure people's privacy and dignity was not compromised.

Requires Improvement

Is the service responsive?

Our findings

People told us they mostly received support when they needed it. One person said, "The staff help me get up and ready in the morning and tell me when it's time to go to the dining room. They seem quite helpful." Another person told us, "The staff are here if I need them and know what to do." A relative said their family member was well-cared for at the service. They commented, "They do meet her needs and we are quite happy with the care."

During our inspection visits one person using the service was particularly vocal throughout the day. Some people, and a relative, told us they found this distressing. They said they had spoken to staff about it and staff had told them that nothing could be done. We observed that when staff spent time with this person, and when they were otherwise occupied, they were less vocal.

We checked this persons' care plan which stated that they tended to be vocal when they were 'low or bored'. The care plan told staff to 'reassure [the person] and create an environment to lighten [their] mood'. Although we did see staff reassure this person at times, we did not see them 'create an environment' for them 'to lighten their mood' and it was unclear what this meant. In addition, the care plan did not acknowledge the impact this person's behaviour had on other people using the service. We discussed this with the registered manager who agreed to review the person's care to help ensure that staff were doing everything they could to respond appropriately when this person was 'low or bored'.

The care records we looked at showed that assessments were carried out prior to people coming to the service. Assessments contained information about people's health, personal care, and social needs. There was also information about people's chosen lifestyles, choices and preferences. However this information was not always carried thorough into care plans.

For example, one person's was assessed as having sleeping difficulties prior to their admittance to the service. They daily notes showed this continued to be an issue once they moved in. One entry in their care notes read, 'As usual [the person in question] did not go to his bedroom and spent all night sleeping on and off on different chairs in the lounge.' Another stated, '[The person] did not go to his bed at all and hardly slept'. However there was no care plan for this so staff did not have any guidance on how best to support this person during the night.

Another person had been admitted to the service with a diagnosis of dementia and sight loss. There were no care plans in place for these issues nor any other instructions to staff as to how this person's needs relating to their mental health and sensory impairment should be met. This meant that staff did not have consistent information about how best to provide this person with responsive care and support.

A further person's care records were incomplete. This person, who was receiving palliative care, had an end of life care plan in place. The aim of this was to 'ensure my wishes are supported'. However the person's wishes had not been documented, nor was there any information in their care notes about whether future hospital admissions were appropriate if their condition deteriorated.

Staff told us they followed care plans when they provided people with care and nursing. This meant that if some care plans were missing or incomplete staff would have no written guidance to follow which could have an adverse effect on the quality of care provided.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care. The registered persons had not ensured that care was designed to achieve people's preferences and meet their needs .

We asked people about the activities that were available to them. Some people told us they would like a wider range of activities. One person said, "I sometimes have a game of dominoes, I would like more to do." Another person told us their main activity was watching television although they sometimes played dominoes. They said, "In the morning from 10am to 12pm there is nothing to do, nothing to look at, and nothing to see." A relative told us 'there is not much activity, only occasional ones'.

During the morning of our first inspection visit most people using the service sat in the lounge and conservatory. There were two televisions on at all times. There were books, newspapers, and magazines on a shelf, although people were not accessing them at this time. We did not see any other items of interest around to provide people with a focus or give them the opportunity to do something meaningful, although we observed that staff talked to people when they could. We were shown an activities folder containing information about the activities participated in by each person using the service.

The providers had a part-time activity organiser who told us they usually provided activities in the afternoon. These included both group and one-to-one activities. Recent activities had included board games, music, food tasting, and outings to the shops, a dog show, and a garden centre. One-to-one activities were geared towards what individual people using the service liked to do. Activities were discussed at residents' meetings and people had the opportunity to give feedback on them.

The activities organiser had set up 'Skype' (a software application that lets people have a spoken conversation with someone over the internet) for another person so they could communicate with family members in another country. And another person, who had a first language other than English, had specific one-to-one time with a staff member who spoke the same language as them so they could converse together, which was something the person using the service wanted.

One our second inspection visit to the service we met with the providers' senior activities organiser who told us their job was to oversee and monitor activities in each of the providers' services. He had been brought in to revitalise the activities at Langdale Heights and showed us the plans for a new programme of activities which had been designed to provide more stimulation for the people using the service. He said the new programme would be implemented over the next few weeks.

People using the service told us they would speak out if they had any concerns. One person said, "I know there is a complaints procedure, if I had a complaint I would wait and speak to someone [a staff member] I liked." Another person told us, "[I would] go to the office to report concerns."

A relative told us they were aware of the provider's complaints procedure and said, "I would speak to the [registered manager] if there were any problems". Another relative said they had raised a few minor concerns with the staff and each time the issues had been resolved. They commented, "The staff said they'd rather know if there was something wrong so they can sort it out."

The provider's complaints procedure was in their statement of purpose and also displayed it the entrance

hall. It was in need of updating as it gave the wrong name for the registered manager of the home. It included details of the local authorities where people using the service and relatives could take complaints to if they wished, however it did not provide information about the Local Ombudsman who also has a role in investigating complaints about adult social care.

Requires Improvement

Is the service well-led?

Our findings

According to their statement of purpose the providers had a quality assurance program in place to monitor 'the entire home's services' with particular reference to 'care practices'. We asked to see the relevant documentation and were shown a series of audits covering moving and handling, falls, tissue viability, nutrition, weights, accidents and incidents, infection control, and the premises

We looked at the latest accidents and incidents audit which was for April 2016. This showed there had been only one incident of physical aggression (on 20 April 2016) and no incidents of absconding. However an incident report for 29 April 2016 stated that on that day there had been one incident of absconding and one incident involving multiple assaults on staff. These had not been added to the accidents and incidents audit. The operations manage explained that there had been an oversight by staff on this occasion.

When we inspected care plans and risk assessments were in the process of being audited. However at the time of the inspection not all had been completed so some of the concerns we had about these not being personalised had not been identified.

In addition the premises audit had not identified the health and safety and cleanliness issues we discovered.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. The registered persons had not ensured that their program to assess, monitor and improve the quality and safety of the service had been operated effectively in order to meet statutory requirements.

People using the service and relatives told us they were not aware of any meetings being held to give them the opportunity to comment on the service. Nor could anyone we spoke with recall being asked to fill in a questionnaire about the service. We brought this to the attention of the registered manager who said meeting and surveys had been carried out in the past but not recently. She gave us copies of the survey questionnaires that had been sent out to relatives in January, February and March 2016 as well as being distributed by hand to relatives when they visited the service. This was evidence of people using the service and others having been asked for their views.

We asked people using the service and relatives what they felt about how Langdale Heights was managed. One person said, "I don't see the manager" and another person told us, "I've not seen the manager." A relative said they weren't sure who the registered manager was but thought the service was well-run. They told us, "We're big advocates for this home."

When we arrived for our first inspection visit there was confusion amongst the staff as to who was managing the home. One staff member told us the registered manager had left, "A couple of months ago." Another said the registered manager had taken up a different role with the provider and was no longer managing the service although they were "Dropping in occasionally to check everything was okay." A third staff member said the operations manager, and not the registered manager, was running the service.

During the inspection visit the providers came to Langdale Heights and told us the registered manager was still running the service but had been based elsewhere for the last few weeks. By the end of the day the registered manager was back at the service and told us she would remain there until a new registered manager was found. The providers told us they would make sure that people using the service, relatives, and staff, were clear about this. When we returned for the second day of our inspection visit on 3 June 2016 the registered manager was on duty and the rota showed she was back to working full-time at the service.

When we returned for our second inspection visit staff had sent out a 'customer survey' to get the views of people using the service and relatives about Langdale Heights. The questionnaires for people using the service were easy-read and pictorial to make them more accessible. Five people using the service had completed these. All respondents said they were 'happy' with the staff and made positive comments about them including 'the staff are very kind and friendly'. All respondents said they were 'happy' with how clean and tidy the home was. One person said they wanted more trips out and another person said they thought the garden needing improving.

The registered manager said she would analyse the results of the survey and take action as necessary to bring about the changes people wanted. One relative had also completed a survey in which they said they were satisfied with all aspects of it. They commented, 'We feel [our family member] is very well cared for and the staff are cheerful and helpful.' Carrying out these surveys was an example of staff seeking the views of people using the service and relatives.

Most staff we spoke with said they felt supported by management and were regularly asked for their views and opinions about the service. One staff member told us they did not feel respected by management and said that on one occasion they had been spoken to in an inappropriate way by a senior member of staff. They felt this was evidence that the service lacked an open and supportive culture. We advised the registered manager of this and she said she would discuss it with the providers to see if any improvements were necessary to the way staff were supported.

We looked at the minutes of the most recent staff meeting which had been held the week prior to our inspection visits. The minutes showed that staff had been given updates on health and safety, infection prevention and control, safeguarding, record keeping, and the recruitment process. However as the meeting did not state which staff had attended (or who the chair or minute taker was) we could not be sure if all staff had been made aware of the information given at the meeting. We also noted there was no recorded opportunity at the meeting for staff to share their views about the service. We discussed this with the registered manager who said that in future staff would record this part of the agenda.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered persons had not ensured that care was designed to achieve people's preferences and meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had not done all that was reasonably practicable to minimise the risks to the health and safety of the people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered persons had not ensured that people using the service were protected from abuse and that their systems and processes to prevent and investigate abuse had been followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had not ensured that their program to assess, monitor and improve the quality and safety of the service had been operated effectively in order to meet statutory

requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had not ensured that staff employed by the service had received the appropriate support and training to enable them to carry out the duties they were employed to perform.