

Langley Haven Care Home Ltd

Langley Haven Care Home

Inspection report

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Berkshire
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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?	Outstanding ☆

Summary of findings

Overall summary

Langley Haven Care Home provides accommodation and personal care to older adults, some who have a diagnosis of dementia. The service is a mock-Tudor style building with three floors and located in quiet residential cul-de-sac. There are 33 en-suite single bedrooms and one double room, with one assisted bathroom and two shower rooms. The service is registered to accommodate up to 35 people. At the time of our inspection, 34 people used the service.

At our last inspection, the service was rated good.

At this inspection we found the service remained good.

Why the service is rated good:

People were protected from abuse and neglect. We found staff knew about risks to people and how to avoid potential harm. Risks related to people's care were assessed, recorded and mitigated. The management of risks from the building were also considered. We found appropriate numbers of staff were deployed to meet people's needs. Medicines management was safe, and staff focused on the prevention of errors. We saw some refurbishments were completed to modernise the building and provide more bedrooms and communal spaces.

Staff training and support was good. Staff had the necessary knowledge, experience and skills to provide appropriate care for people. The service was compliant with the requirements of the Mental Capacity Act 2005 (MCA) and associated codes of practice. People's nutrition and hydration was closely monitored. Appropriate access to community healthcare professionals was available.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

There was a lot of complimentary feedback about Langley Haven Care Home. People and others told us staff were accommodating. People and relatives were able to participate in care planning and reviews and some decisions were made by staff in people's best interests. People's privacy and dignity was respected.

Care plans were personalised and reviewed regularly. There was a satisfactory complaints system in place which included the ability for people and others to escalate complaints. People and relatives told us they had no complaints, but knew the process for raising any concerns.

Management and operation of the service was outstanding. All staff worked continuously as an effective team to improve care, ensure people were safe and focus on the quality of the service. Langley Haven Care Home was awarded multiple prestigious industry awards for the improvement the care provided made to people's lives. Innovation, research and continuous assessment of support for people were all a standard

part of the service. The service had excellent working partnerships with external agencies dedicated to the improvement of adult social care.

Further information is in the detailed findings below.

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 remains safe.	Good ●
Is the service effective? The service remains effective.	Good ●
Is the service caring? The service remains caring.	Good ●
Is the service responsive? The service remains responsive.	Good ●
Is the service well-led? The service was well-led. People's experiences were improved by a service focussed on the quality of care. People's social lives were actively supported in order to maintain their physical and mental well-being. There was a continuous learning culture to ensure people's risk of harm was reduced or eliminated. The service worked collaboratively with community-based agencies involved in the improvement of adult social care.	Outstanding ☆

Langley Haven Care Home

Detailed findings

Background to this inspection

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

Our inspection took place on 24 August 2017 and was unannounced.

Our inspection was completed by two adult social care inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our Expert by Experience was familiar with the care of older adults who live in care homes.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we already held about the service. This included notifications we had received. A notification is information about important events which the service is required to send us by law. We also looked at feedback we received from members of the public, local authorities, clinical commissioning group (CCGs) and the fire inspectorate. We checked records held by Companies House, the Information Commissioner's Office (ICO) and the Food Standards Agency (FSA).

During the inspection we spoke with the registered manager, head of care and seven care workers. We also spoke with the chef, the activities coordinator and the maintenance person.

We spoke with eight people who used the service and three relatives. We looked at all nine medicines administration records and seven sets of records related to people's individual care needs. This included care plans, risk assessments and daily monitoring notes. We also looked at three staff personnel files and records associated with the management of the service, including quality audits. We asked the registered manager to send further documents after the inspection and these were included as part of the evidence we used to compile our report.

We looked throughout the service and observed care practices and people's interactions with staff during our inspection.

Is the service safe?

Our findings

People told us Langley Haven Care Home was a safe service. One person told us, "I am very happy here. I have told social services I want to stay. I am safe and happy here. The staff are like family to me." Another person said, "On the whole I am very happy here, obviously I would rather be in my own home but I can't manage there by myself and they give me lots of help with things like washing and dressing. They do their best." A third person stated, "I came here because I'd had lots of falls and I couldn't be at home any more. It makes me feel safe knowing there are people around to help me. I have help with things like washing and dressing."

Relatives also provided positive feedback. A relative told us, "They are looking after [my loved one] very well. I don't think she's getting any better but she's happy and there's always plenty of staff around. They do a wonderful job, they're marvellous." Another relative stated, "I am very satisfied and I can definitely say [my loved one] is safe living here. I can't fault the place." A third relative told us, "My mother came from another home and I worried about how she'd cope with the change but she has settled in and taken to it really well. It's a bit bigger than the last place but she has been persuaded to walk again. The staff seem more on the ball. The staff and structure of the care is better and the rooms are lovely."

People were protected from abuse and neglect. We found staff were trained in the protection of people at risk during their induction and on a recurring basis. The registered manager showed us evidence of this. When we spoke with the registered manager and staff, they were knowledgeable about types of abuse and what to do if they suspected people were at risk of harm. We saw there were suitable procedures in place that protected people from the risk of abuse and avoidable harm. The service had information about the local authority's safeguarding measures which were available to staff. We found the registered manager took appropriate action when they identified people who were at risk of harm or when harm occurred. The registered manager demonstrated they liaised with the local safeguarding team and police to make sure any concerns were fully investigated and action to prevent further harm was implemented. The registered manager also notified us if there were any allegations.

The service ensured that people were protected from harm that could be caused by the building, equipment and grounds. Appropriate risk assessments were conducted, reviewed, acted on and stored. Examples we viewed included the fire risk assessment, gas safety certificate, checks of the electrical wiring in the building, portable appliance testing and period inspections on lifting equipment like the hoists and passenger lift. These were current and risks from these items were acceptably mitigated.

There was a Legionella risk assessment completed in 2016. This showed that the service required some actions to ensure people were adequately protected. Together the management team and maintenance person increased the amount of checks undertaken. A water sample result from 2017 showed there was no Legionella present in the water system of the service. However, building works to expand the service were completed in late 2016 and this necessitated a new risk assessment to be completed due to new pipework. This was undertaken in May 2017 and showed the risks to people were well-managed. The service was encouraged to continue the safety programme they implemented in 2016 to prevent Legionella.

We recommend that the service ensures continual adherence with the Health and Safety Executive's approved code of practice for the prevention and control of Legionella.

We looked at seven people's care files to check the service satisfactorily assessed, documented and managed risks to people related to the provision of personal care. We saw pre-admission assessments were completed in all instances and contained relevant information such as likes and dislikes along with baseline observations and pre-admission weight. People's medical histories were obtained from their GP and recorded in the pre-admission assessments. In all of the care files we reviewed, we found risk assessments included falls risks, the malnutrition universal screening tool (MUST), moving and handling, and risk of pressure ulcers (Waterlow scores). In all instances we saw these were reviewed on a monthly basis; sometimes more frequently. People's weights were monitored on a regular basis to ensure people were not at risk of malnutrition. MUST assessments ranged from low to high risk, and where needed we saw there was involvement of a GP and nutritionist.

People who used the service were rarely involved in incidents or accidents. We reviewed two accident and incident records. People's falls and resultant injuries were appropriately documented on incident reports by staff, sent to the management team, and then entered into a computerised database. The management team reviewed all of the reported injuries and completed detailed investigations of the staff actions. The provider's head office had access to the computerised records so that they could identify trends or themes about the injuries. We saw the registered manager also tracked any incidents or accidents. The focus of the incident and accident investigations was how the staff and service could learn from the event and what could be put in place to further protect the person from future harm.

Staff who were offered employment at Langley Haven Care Home experienced a robust recruitment procedure. This meant people and relatives were assured that fit and proper checks of new workers were completed. We examined three personnel files of the newest staff that commenced employment. We found all of the necessary checks were on record. This included verification of staff identities, criminal record checks from the Disclosure and Barring Service (DBS), checks of conduct in prior employment and the right to work in the UK. Staff were interviewed by the management team and selected based on their relevant knowledge, skills and experience.

People received good support and treatment because there was appropriate deployment of staff. We spoke with people who used the service, relatives and staff about the amount of staff and ability of them to undertake care for people. There was positive feedback about the staff. One person living at the service said that they felt there were enough staff. They told us, "It's amazing how quickly they come when you ring the bell." A staff member told us, "You have time to talk to people. There are busy times but it's great." The management told us that staffing was calculated based entirely on people's dependency levels. However, this was not the only method used to determine sufficient staffing on each shift. The service had considered people's behaviours, and that a good ratio of staff meant that social isolation could be avoided. The registered manager, who was a registered nurse, also worked regularly with staff on shifts to provide care and support or complete the medicines administration. They told us this ensured that the service knew if staff levels were safe. During our inspection, call bells rang quite frequently. We observed people did not have to wait for staff assistance and call bells were answered promptly. This included when people had sensors attached to them which would alert staff if they left their chair in communal areas and were at risk of falls.

People's medicines were safely managed at the service. In the morning, we noticed two medicines trolleys were used. When we asked a care worker, they told us this was so people would receive their medicines in a timely way during or close to their breakfast times. Medicines were dispensed to each person directly from

the medicines trolleys. The medicines administration records (MAR) were correctly completed. Regular medicines audits were completed by senior staff and external audits completed by a community pharmacist. Medicines that required stricter controls by law (controlled drugs) were securely stored and correctly documented. All staff were trained in the administration of medicines and had regular competency checks. Temperatures of the fridge and room where medicines were stored were checked and appropriately recorded. We observed one care worker complete people's medicines administration at lunchtime. They asked people if they had any pain before giving analgesics. We saw they were methodical in their approach and used the correct techniques. They did not allow themselves to become distracted by other events. This reduced the risk of errors and protected people from harm.

Is the service effective?

Our findings

We asked people and their relatives about the effectiveness of care provided at the service. All of the people and relatives we spoke with provided positive feedback. One person said, "In everything the staff do for me I could never say anything is wrong. They are always on the go, always happy to help and they know what to do and how to do it. The food is very good. The chef asks what I like and cooks it for me. If I need to see the doctor they call him and if I need to go to hospital they take me. What more can you ask?" The next person stated, "The staff are well-trained to look after me and they're always polite. The food's not bad. I eat what's put in front of me. Touch wood I've never had to see the doctor yet but if I was ill they'd get him to come and see me, I know." Another person commented, "I don't need help eating. The food is good...I've had a problem eating because I lost my dentures but they took me to the dentist and got some new ones made."

A relative told us, "I come every day. I have to, [my loved one's] all I've got left. The staff are very well-trained. They've got new staff recently and they all seem to be very good. The food is excellent and my wife eats well now. I think she's put on weight. If she's been under the weather, they are straight on it and call the doctor out." The next relative we spoke with said, "The staff are very good. My [loved one] shouts a lot but they are so patient and reassuring with him that he calms down. I come every day and give him his lunch. They mash it up really well so that it's easier for him to eat." A further relative stated, "Using my [loved one's] previous home as a yardstick, I think the staff are very well-trained. They involve me fully in the decision-making process over her care plan. I've eaten at the home when I've visited her and I think the food is very good. Her weight is going up now. When she's been under the weather they've called the doctor in and let me know. They organise visits to the dentist and they have a chiropodist as well. It's very good care."

New staff underwent a period of induction which included mandatory training in subjects such as moving and handling, fire safety and infection control. Two staff members informed us that, despite having previous experience working in other adult care services they still had to undertake this training before being allowed to support people living at the service. One described how that after initial training, they only worked with experienced senior care workers during their shifts, until they got to know people's needs.

A new care worker described how they looked at people's care plans to help them find out about their needs and commented, "You find out by asking them, but I have had a chance to look at their care plans and they're very good."

Records we examined, and the comments of staff we spoke with, indicated that staff had received a broad spectrum of training that was relevant to their roles. Training was a mixture of e-learning, external and in-house courses. The registered manager kept a training matrix that recorded the training staff had received, along with the date they required refresher training in each specific subject.

Staff we spoke with told us of the care qualifications they had obtained such as diplomas in health and social care and their nursing qualifications from other countries. Although the service provided only residential care, staff we spoke with told us they could use their nursing knowledge to provide better care and support to people. We saw one care worker was commencing formal qualifications in infection control

and medicines management. Some staff had received training with regard to supporting people living with dementia, although one staff member we spoke with thought that more staff would benefit from this.

Staff confirmed that they had attended supervision sessions with a senior staff member, and senior care workers confirmed that they undertook supervision sessions approximately every three months. We found the registered manager recorded staff supervisions on a matrix in order to check how regular sessions were being held. One senior care worker stated, "We've got a good team; we have a good level of staff and good opportunities for training."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

When we asked people if staff sought their consent before offering support such as personal care. One person said, "Oh yes, and sometimes I say 'no thank you' and it's fine by them." People's care plans we viewed contained mental capacity assessments relating to the care and support they required. These were reviewed every three months. DoLS assessments had either been requested or carried out for those that had been assessed as not having the capacity to make complex decisions, such as moving into the service or agreeing to the care and support offered.

Records in care plans indicated that, where people lacked capacity, their legally-appointed decision-makers were involved and consulted about their care and support. Copies of documents such as enduring power of attorneys and Court of Protection orders confirmed their ability to make decisions. The registered manager told us of one person who received their medicine covertly. We saw that the person had a current DoLS order and that a "covert medicine administration" form had been signed by the person's power of attorney, GP and a pharmacist.

Staff we spoke with confirmed that they had received training in relation to mental capacity and DoLS. When asked what they would do if a person refused their support one said, "I would just go out and try again later. It's their choice." Another said, "It's 24-hour care here. It's their choice if they want to stay in bed or get dressed late in the afternoon; it's okay by us." When asked about how important decisions were taken for those that lacked the capacity to do so, a senior care worker said, "You have discussions with their GP, relative or social worker and record it." This indicated the service used the best interest decision-making process where necessary.

Records we reviewed indicated that people were weighed each month and a nutritional risk assessment was completed. We found the home had two nutritionists in employment. The amount people ate and drank during the day was recorded on a "24hr daily report" form. We found the records we viewed were fully completed and indicated that people were receiving adequate amounts of food and drink. We saw one person required the full support of staff to eat their meals. We found their care record showed that their weight had remained steady over the previous eight months, indicating that they had received adequate nutrition.

There was evidence that showed people had access to healthcare services and received ongoing healthcare support. People were registered with one of four local surgeries. The registered manager stated that people were either taken to see their GPs or a telephone consultation was held. GPs also visited the service for urgent cases, although one staff member said that this was sometimes only after they had been requested to do so via the 111 telephone service. Records in one person's care plan indicated that they had lost around

four kilograms of weight over a one month period. We found that they were promptly referred to their GP and reviewed by one of the service's nutritionists.

A person had developed a pressure sore on their heel prior to moving into the service. We found that community nurses visited the to carry out the dressings and that they had also attended appointments with a podiatrist. Another person had heart failure. Their care plan contained a NHS information leaflet which described the signs of heart failure and containing the telephone number of a specialist nurse. This helped staff have relevant information ready if the person's condition deteriorated. Other care plans we viewed indicated that people were seen by a variety of healthcare professionals such as GPs, physiotherapists, the community mental health team, hospital consultants, podiatrists and opticians.

We looked at the adaptation, design and decoration of the service. All bedrooms had a separate toilet and a basin. Lifts were available that accessed the two upper floors of the building. The lifts were suitable for people who used wheelchairs. There were shower rooms on each floor and a bathroom on the ground floor. The bathroom was spacious and contained a bath and bath hoist suitable for people with mobility problems. We were told there were plans to decorate two areas of the service to specific themes in order to give some visual stimulation for those living with dementia. One area was to be decorated as a 'high street' and another with a seaside theme. We saw that some work had commenced regarding this. One area at the end of a corridor had been themed as a bus stop with seating. There were small shelves in corridors upon which were objects that could prompt people's memories or that were tactile.

There was a large communal lounge with an adjacent seating area. Other lounges were available throughout the service for people to use should they require some privacy, or somewhere quiet away from the main communal lounge. One separate seating area off of the main lounge was called the 'reminiscence lounge' and contained many objects that could be a reminder of the past and stimulate conversations between people, staff and visitors.

We found the provider had planned the building surroundings carefully. Externally, there was a level, paved pathway around the outside of the service that was suitable for people with limited mobility and those who used wheelchairs. The pathway led through raised garden beds that contained flowers, herbs and vegetables that the activity coordinator said were planted by people who used the service.

Is the service caring?

Our findings

As part of our inspection, we observed people's interactions with care workers and how care was provided in the dining room and communal lounges. During our inspection, we saw staff were consistently kind and caring. In one instance, we noted a person's foot had fallen off a cushion that prevented them from developing a pressure ulcer on their heel. As a staff member walked by, they noticed this immediately and made sure the person's foot was repositioned in the correct way. We also noted that the maintenance person sat down at one point and had a conversation with one of the people who used the service. In another instance, the kitchen staff asked two people to help fold napkins at the dining table and we observed they enjoyed helping the staff.

We found the staff were caring. One person said "The staff are just lovely. They are so gentle and polite with me. They know what I like and what I don't like. They encourage me to do what I can for myself and I go on some of the trips out. They always try and do what they can to make it easier for me." Another person we asked told us, "The staff are very kind. I get enough help for my needs. I don't know if they ask permission to help me or whether they just do it but they always knock on the door before coming into my room and make certain I've got a dressing gown on if I'm going to the bathroom. I think I'm well looked after." A third person said, "The staff are very kind and explain what's going on and why. Sometimes I forget but they explain again. They are very patient with me. I'm happy to be here."

Relatives agreed with the people who told us staff were caring. One said, "The regular staff that I've seen are very caring. There's lots of new ones and I'm waiting to see how they pan out. They always come and talk things through with me and if they have to make any changes to [my loved one's] care they explain why to me. We haven't talked about end of life care yet; I'm not really ready to face that." A second relative commented, "I've watched them with my [loved one]. They always look her in the eye and talk to her with a smile. I think they're very caring." A further relative told our inspection team, "I've always found the staff very welcoming when I've come to see my [loved one]...really friendly and helpful and that goes for all of them; from the top down to the maintenance man and the cleaners. They always approach me and tell me what's been happening. I never feel that there may be things happening that I don't know about. [My loved one's] dementia is getting worse but I feel happy that she is in the best place now."

During our inspection, we saw that staff supported people's privacy and dignity. Staff we spoke with told us they would speak with people and seek their consent before they commenced any care or support. We found people were appropriately clothed and presented, addressed by their preferred names and we saw that the service supported people's independence as far as possible.

People's confidential personal records were protected. The office computer used for recording information was password-protected and available only to staff with the appropriate access. Paper records of care were maintained, but where these existed they were locked away so that there was restricted access to staff only. Staff records or documents pertaining to the management of the service were also locked away. In some instances, where there was sensitive information, the records were only accessible by the registered manager.

At the time of the inspection, the provider registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 (DPA) requires every organisation that processes personal information to register with the ICO unless they are exempt. We wrote to the registered manager about this after our inspection. This ensured people's confidential appropriate information was recorded, handled and disclosed according to the legislation.

Is the service responsive?

Our findings

People and relatives we spoke with felt care at the service was personalised and in some cases, had improved physical and mental wellbeing. From those we spoke with, no one had complaints about the care but everyone knew what action to take if they did have concerns. People's wishes and preferences were respected.

One person we spoke with told us, "I've never had to complain. Anything I need I just have to ask the staff and it's done. They know how to look after me and take care of me; I trust them. I don't have a male carer. I wouldn't feel comfortable with that but that's no problem to them. If I have to go to the hospital or dentist or anything they sort it all out and take me." Another person said, "I like the activities. There's always something going on and the outings are really nice. We went to the Windsor horse show and that was lovely. If I had to complain I'd speak to the boss. He's a very nice man; very kind but I haven't needed to complain at all." A further person stated, "They asked me if I minded having a male carer and I said no I didn't want one. It was my choice and they respected that. I love the activities, particularly the outings. The staff are always cheerful and if you're not happy about anything they do their best to sort it for you straight away. I think I could speak to any of the staff if I wanted to complain but I've never had to."

A relative told us "If I had to complain I'd speak to the manager but everything is ticking along just fine. [My loved one] is happy. They (the service) talk things through with me. I'd complain if I had concerns and I think they'd be straight on it. It seems that kind of place. They have lots of entertainment which I think is really helpful, stimulating rather than just leaving them (people) to sit endlessly. I think it's difficult to give [my loved one] choices given the level of her dementia but I think they're looking after her well and I have no complaints." Another relative said, "They went through the care plan with me when [my loved one] came in here but it's always under review as his dementia increases. They always tell me if there's any changes and check that I understand what is being done and why. They have more male staff now and he has men to help with his personal care. That's a good thing because I think he was getting difficult for the [female staff] to handle. I can honestly say I've never had any concerns or felt I had any reason to complain. They look after him well." Another relative's comments included, "[My loved one] hasn't been there long but I think she has picked up a bit since she moved there. She was very depressed before...she spent a lot of time left just sitting. Now with all the activities it seems to have picked her up a bit, and she does take part in them. I thought she might have been past that stage. If I thought I needed to complain I would straight away, but as yet I can't find anything to complain about."

We found people's care plans were comprehensive, up-to-date and were based on assessments of their individual needs. At the front of the care plan was a "resident profile" that gave information about the person. Details were recorded such as the name they liked to be known as, their next of kin, general practitioner, medical history, social worker or advocate, allergies, resuscitation status and whether they were subject to a DoLS authorisation. We found that the information recorded regarding people's resuscitation status, which required a "yes" or "no" answer, may have been ambiguous as the question related to whether there was a 'do not attempt cardiopulmonary resuscitation' (DNACPR) order in place, and not whether resuscitation should be attempted. We brought this to the registered manager's attention

who said they would review the current method of recording.

Near the front of people's care plan folders, we saw there was an abridged version of their main support needs that was used as a quick reference guide for staff. Information recorded included what they liked to be called, important people in their life, hearing, eyesight, activity interests, level of assistance for personal care, mobility aids, bedding and pillow preferences, favourite TV programmes and favourite meals. This helped staff to quickly locate information about each person without searching through someone's entire records.

Care plans we viewed contained preadmission assessments that had been carried out by the registered manager, in order to ensure the service was able to meet the person's needs before they moved in. On admission, staff completed a "needs assessment tool" which covered mobility, personal hygiene, communication, orientation, capacity, eating and nutrition, skin and pressure area care, social care, health, night routine and medications. Specific care plans were then completed following the outcomes of the assessments.

Evidence we found demonstrated that people received personalised care that was responsive to their needs. For example, one person had been assessed as being at high risk of developing pressure sores. Their care plan stated that they should be provided with a pressure relief air mattress and a pressure relief cushion for their wheelchair. The care plan also recorded that the staff should check for any pressure damage to the person's skin each day. We visited the person and found that the correct equipment was provided and was in correct use. The person said that the staff ensured that the equipment was working and also checked their skin for damage each day. This showed that staff followed care plans to ensure the person's skin remained healthy.

Another person we spoke with had mobility problems. We saw an appropriate care plan was in place relating to this, which described the equipment and help the person required when moving from their bed to their chair. The care plan stated that two staff were needed to support them to do this. We found that the right equipment was available and the person confirmed to us that two staff supported them whilst using it.

Another person sometimes became aggressive towards staff whilst receiving personal care. Their care plan described how staff should, "Attempt to [capture] and hold [the person's] attention before you start to talk and make eye contact. Attempt to minimise competing noise such as TV and radio." We spoke with a care worker who confirmed this was practiced and was effective when they supported the person.

We checked whether people experiences, concerns and complaints helped improve the quality of care at Langley Haven Care Home. We looked at the records of residents' and relatives' meetings. We saw there were three held in 2017. The meetings were chaired by the registered manager. We found many people and relatives attended the meetings, which was a good sign of the service's positive relationships with them. For example, we found the last meeting was held in July 2017 and was attended by 32 people who used the service and 10 relatives or friends.

We found people and relatives were given the opportunity to contribute to the meeting. We saw issues raised from previous meetings were acted on by the registered manager and provider. This included the reintroduction of 'keyworkers' and plans to fully enclose the external perimeters of the building with fencing, so that people could access the area safely. People at the service were fully informed of various projects, such as the clinical commissioning group's (CCG's) hydration project and the themed decoration of various areas.

The service had a satisfactory complaints policy and we looked at the complaints log for this year. The registered manager dealt with all recorded complaints promptly and any outcomes and actions were recorded. One staff member told us how they would deal with a complaint from a person or relative. They said, "I would write it down and go to the [registered] manager. If they didn't deal with it, I would go to the [operations] manager, an Ombudsman or the CQC."

Is the service well-led?

Our findings

At our inspection, we found that the staff, management and provider of the Langley Haven Care Home were committed to and participated in outstanding practices and innovation to enhance the lives of people who used the service. People, relatives and healthcare professionals were aware of, and actively participated in various projects to increase people's life expectancy and the experience of living in a care home. We found evidence throughout our inspection that the service strived for the best possible care and support for people and this had a positive impact. We were provided with multiple examples of outstanding care. The service was rated within the top 20 care homes in England in 2015 by a leading adult social care website. This was based on the contents, ratings and number of reviews submitted by people who used the service, relatives and friends, and healthcare professionals. One review from 2017 stated, "The staff are very welcoming and include you in mealtimes...staff go beyond expectations and regular visits/trips out are arranged. Entertainment is very good. [We] cannot fault the staff."

We heard how the local clinical commissioning group (CCG) ran a hydration project throughout east Berkshire. The purpose of the project was to reduce the number of urinary tract infections that people in care homes developed. Langley Haven Care Home embraced the project once they were invited to participate. Prior to the project, the service already actively monitored the number of urinary infections each week and month. We saw this equated to approximately three or four each month that required GP visits, prescriptions for antibiotics and on some occasions, hospital treatment. The management team met with the CCG pharmacist and gathered the necessary information to participate in the project.

Staff were provided extensive training about what actions were required in order to prevent infections. Amendments were made to the location of and frequency of provision of fluids to people. We saw people were actively encouraged to drink fluids throughout our inspection, especially between mealtimes. Hydration tables were available throughout the building so people could help themselves and as a visual cue to staff, relatives and friends for offering drinks. Once the project had commenced within the service, no one developed a urinary tract infection. This was displayed by green dots posted on a board which showed the number of days that no infections were detected. We saw this was sustained for more than one month. When we spoke with the registered manager they told us they planned to continue the system of fluid intake to prevent any urinary infections. People's experienced less infections, had better health outcomes and there was less reliance on GP visits, medicines prescriptions and administration and some hospital admissions were completely avoided.

The registered manager told us of the service's focus on reducing and preventing avoidable harm people experienced from falls. Although records showed a small number of people had sustained fractures from falls in the past, this was significantly reduced by a number of strategies put into place. The registered manager told us the aim was to have zero falls at the service. Standard risk assessments and care plans were used to assess and mitigate everyone's risk of a fall. However, when high risks were identified, the service used additional methods to reduce or eliminate the risk that someone would have a fall. Examples we saw included a "tracking" chart used over a period of time to provide a visual projection in a graph format of a person's ability to safely move with or without assistance. Staff could monitor any decline or improvement

and adjust care rapidly to prevent the person falling or increase their independence by reviewing the use of mobility aids. In the rare occasions where a person fell, a full analysis of what precipitated the event and how the fall occurred was completed. We looked at two examples. We saw all aspects that could have caused the fall were examined. These included eyesight, hearing, medicines reviews, clothing and footwear, the premises and equipment. Where a root cause of a fall was suspected, changes were made to the person's care to prevent recurrence. For example a podiatrist was consulted if a person's shoes were seen as the likely reason for the fall or a GP and pharmacist reviewed medicines to see if drowsiness or low blood pressure was the potential trigger for the fall.

The service had examined and commenced implementation of even more strategies to prevent people falling and protect people from fractures and other injuries. After seeing a journal article in a clinical magazine about the use of technology to prevent falls for older adults, the registered manager contacted the author. The two parties had agreed to undertake research at Langley Haven Care Home. This was through the use of 'artificial intelligence'. After consultation and consent from people, the university hospital would install closed circuit cameras (CCTV) into all communal areas within the building, including corridors. The CCTV would monitor each person's movements throughout the day and night. Using a computer programme, the system would analyse people's mobility and alert the service's staff to potential decreases in people's safety of walking. We were told the system would track people's movements and also recognise a person who was about to or likely to fall. An urgent staff response could then be used to attend to the person immediately. Over time, the system would also track and trend people's mobility which could be compared with their general health. The findings from the programme would be used nationally to further inform social and healthcare professionals of processes to reduce and prevent falls.

We saw Langley Haven Care Home won first place in 2016 'care home of the year' for the provision of outstanding social lives to people who used the service. The service received the accolade from an annual national healthcare and pharmaceutical awards ceremony. We looked at the social lives that people who used the service led. We found that people were not continually confined to the premises, communal lounges or their bedrooms. The service had a minibus which was used frequently. Instead, trips into the community were the norm. We saw events included a night at the theatre, a trip to Windsor by train, a visit to a motor museum, a picnic in the garden of a stately house, and a visit to the local fire station for a firefighting demonstration.

The activities coordinator at the service was the southeast regional finalist and national winner in the 'Great Britain care awards 2017'. This was awarded for their commitment to enhancing people's lives. We saw that when activities inside the service were planned and operated, these were based on people's choices and preferences and not standardised. For example, one person stated they were "young at heart" and had a '39th' birthday celebration in lieu of their true age. Another person said they wanted a traditional birthday, and a 'Bollywood' style party was held with traditional dancers. We heard people were encouraged to dance with the entertainers. Another person liked Mexican-themed events, so the service organised an authentic Mexican performer to come with a guitar and sing and dance in Spanish. People and relatives we spoke to told us they "loved" the social life they had and were very proud of the staff that organised the activities.

Another example of using novel ideas to enhance people's lives was that the service hosted an activities coordinator and care home manager from New Zealand and Australia. When the overseas staff members visited, they were able to share ideas with the service's staff and also take ideas away back to their own services. The activities coordinator joined a worldwide network who shared ideas for care homes via regular postcard sent to and from each service. New ideas could be pilot-tested at the service to see if people liked a change or something they had not tried before.

We saw the service participated in the National Citizen Service (NCS) which is a government-run initiative for 15 to 17 year olds to gain different work and life experiences and encourage them into employment. We were told in 2016, three young people came to the service to learn and participate in caring for older adults. The registered manager told us all three young people who took part had benefited from their experience and that they had a better understanding of whether their chosen career could possibly be within social care. One of three youths produced a video on what it was like to live with dementia. With consent, they interviewed and recorded daily life to raise awareness amongst younger people of the experiences of people with dementia.

The registered manager also told us that people who used the service were grateful for the participation of the three youths. People said they enjoyed listening to the youths' experiences of life and were able to have meaningful conversations with them. The registered manager told us they planned to host more youths through the NCS scheme. Students from a two local primary schools also often came to the service to participate in arts and crafts with people. The registered manager told us this was based on research which showed young people have a positive impact on the life of people with dementia. On a reciprocal basis, people who used the service were to visit the primary school and take part in some classroom-based activities. After this, people could reflect on their experience of school and the current methods of learning.

Other examples of leading a normal life within the service included frequent visits from a hairdresser at no cost to people who used the service. They told us they wanted people to "look and feel great." We saw the hairdresser actively encouraged people to have a makeover or have their hair done. We witnessed one person who was adamant they did not want to go to the hairdressing room in the service. The hairdresser told them they could do the person's hair anywhere they wanted, and the person agreed as they wanted to look good. We also saw the hairdresser come to the communal lounge and participate in various activities with people during our inspection. We asked the management team, staff and activities coordinator what impact the social programme and external stimulation had on people's lives. They told us the activities and social events were devised to prolong people's physical and mental wellbeing. They said these were part of the everyday care and support within the service, and not ad hoc or 'one-off' events. The management felt that increasing people's interaction in everyday events had proved to sustain independence, reduce falls and depression, encouraged people to communicate more often. We observed there was frequent communication and social dialogues between people during all parts of the day.

A wide range of audits and checks were used to measure the safety of care and quality of the service people received. The results from the audits were used to drive continuous improvement. We found this was at the core of the management and provider. We saw these checks were regularly repeated and measured against prior findings. Examples of audits we viewed included infection control, catering, health and safety, care plans and medicines. Where improvements or changes were required, the registered manager took action to ensure this occurred. The actions were sometimes delegated to other staff members but the management team always ensured they followed up on the outcomes. The operational director and provider required data to be submitted daily and weekly to the head office. These were used to compare services and further drive improvements across the provider's small group of services.

Accidents and incidents that involved people were recorded and acted on. We looked at two injury reports from 2017. We saw all of the necessary details were included about the person, any harm that was sustained and what actions were taken as a result of the incident. We also noted the registered manager had reviewed each report, made notes and signed off each one before filing them. In some instances, the registered manager made recommendations about how to prevent the same instance recurring.

Obligatory regulatory requirements were satisfactorily met. These included display of the ratings poster in

the building and on the service's website, having an up-to-date statement of purpose, and being open and honest with people and relatives when notifiable safety incidents occurred. There were times when the service was legally required to notify us of certain events which occurred. When we spoke with the registered manager, they were able to explain the all of circumstances under which they would send statutory notifications to us. We compared information we already held about the service prior to our inspection with that from other agencies and the service itself. Our records showed that the service sent all required notifications to us. This meant we could properly monitor the service between our inspections.

We noted a positive workplace culture amongst the staff. Information from multiple sources demonstrated that staff liked to work at Langley Haven Care Home. Throughout our inspection, we observed a jovial, welcoming atmosphere and staff who worked well together in a team. Staff and people joked and laughed during the day. Staff meetings were also held between the workers and management team. We saw the meeting minutes. We noted items discussed included clinical matters like infection control, managerial items that included leadership and learning, individual people's care and changes and the hydration project with the CCG. When we asked staff at our inspection whether they felt they had the option to provide feedback or make suggestions, they confirmed they did. Staff told us that the management team were approachable and that they could speak with them about any topic.

People and staff told us the service was well-led. A person who used the service told us their opinion of the registered manager. They said, "He's exceptionally attentive" and the service provided an "excellent service." A care worker commented, "[The registered manager] is very good; any concerns or questions you can go to him." Another care worker told us, "He's fine, approachable and he does things there and then." Another said "We can always go to him if we want any advice." Staff confirmed that the operational director visited the service twice weekly. One staff member described him as, "Very approachable" and another said, "He is very much down to earth. Everybody likes him."

Other comments we received from people and relatives demonstrated the service strived to provide the best possible care and support. One relative said "I get feedback forms to fill in from time to time. What can I say; they look after her well, they are kind and considerate of her, they talk to me about what's going on. I think it's a very well run home." Another relative told us, "The staff always seem to try and do more to make the residents' lives enjoyable. The activities, the trips out and things like that. I'm trying to think of anything I would change except obviously I would rather she was well and at home with me. I think it's a very well-run service. They look after her and they are always kind to me when I come in to see her. They send out these forms for me to fill in but I can't do more than say they are excellent and I would recommend them to anyone who needed care." A person who used the service said, "They're doing they're best and no one can do more than that." A further relative commented, "I don't think you could get better care. If I think something should be done differently for my [loved one] I say and they seem to listen and be prepared to try out what I suggest. I think they're doing a good job. They do send out the feedback forms and I fill them in and send them back. I've no complaints at all."

The service ensured that people had access to the information they needed in a way they could understand it and were compliant with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 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. We were told some staff could speak languages other than English. People's support plans also included information about how to effectively communicate with them.

We saw that staff were very knowledgeable about the people who lived at Langley Haven Care Home and their individual lives. Care workers understood people's needs and knew them well. When we asked staff,

they told us there was less reliance on reading paper-based care plans and more emphasis on "getting to know the person instead." We saw many example of person-centred care at the service. We saw one person seated in a lounge chair spoke to people passing by in Italian. We then saw a care worker pass by, stop and have a conversation with the person in Italian. When we spoke with the staff member further, they told us the person's dementia had affected their ability to speak in English. The staff member was able to speak Italian and told us they spoke regularly with the person so they felt included in the everyday life of the service. This demonstrated that staff had built unique, positive relationships with people they provided support to.

The service catered for people from culturally and linguistically diverse backgrounds. There was an appropriate underlying policy which reflected the need for the service overall and the staff to respect people, and value their diversity. This was reflected in the systems and processes we observed at Langley Haven Care Home. When we spoke with the chef about people's food choices based on their culture or religion, he was aware of different requirements. The chef was able to talk to us about some people that used the service whose diet was different to others because of their beliefs. The registered manager also told us that the service would adapt their care, as far as possible; to meet people's needs who had particular requirements. Staff we observed and spoke with were also from a variety of different cultures, but worked and communicated effectively. We observed staff respect each other's individual qualities and the registered manager knew staff's preferences. The registered manager told us he made arrangements to accommodate different religious celebrations throughout the year, to ensure that everyone had the right to take part in their respective faiths. This was good evidence of the service's ability to respect and value each person who used the service, their families and the staff that provided the care and support.