Amethyst Arc Ltd

Mandalay Care Home

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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection was carried out on 21 and 22 April 2016. Mandalay Care Home provides accommodation and personal care for up to 46 people.

There were 40 people living at the service at the time of our inspection. There is a small separate dementia unit in the service called the Sunflower unit. There were ten people living in the Sunflower unit and 30 people in the residential unit. People cared for were all older people; some of whom were living with dementia and some who could show behaviours which may challenge others. People were living with a range of care needs, including diabetes. Some people needed support with all of their personal care, and some with eating, drinking and their mobility needs.

The service had a registered manager in post. A registered manager is a person who is 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.

Mandalay Care Home was last inspected on 21 and 22 July 2014, when concerns were identified about a lack of risk assessments and guidance for staff about how to support people safely and ineffective support for some people at meal times. The provider sent us an action plan telling us how they had addressed these shortfalls.

At this inspection we found required improvement had been made in these areas. However, we identified other shortfalls where some regulations were not being met.

Medicines were not stored at below the maximum temperature; records showed this was a longstanding problem that had not been resolved.

Deprivation of Liberty Safeguarding authorisations had not been applied for where people were unable to consent to restrictions in place; and mental capacity assessments did not meet with the requirements of the Mental Capacity Act 2005.

Auditing, carried out for the purpose of identifying shortfalls in the quality and safety of the service provided, had not been wholly effective.

Management of water within the service, intended to safeguard against the development of Legionella, did not fully meet with the requirements of the services' policy. Other checks were in place to limit the risk of Legionella; however, we made a recommendation that the measures set out in the services' policy are fully adopted.

People's health needs were well managed and referrals to outside healthcare professionals were made in a

timely way.

People were supported by enthusiastic staff who received regular training and appropriate supervision. There were enough staff to meet people's needs.

Staff were caring, compassionate and responsive to people's needs and interactions between staff and people were warm, friendly and respectful. Staff spent time engaging people in communication and activities suitable for their current needs.

People enjoyed their meals, they were supported to eat when needed and risks of choking, malnutrition and dehydration had been adequately assessed and addressed.

People commented positively about the openness of the management structure and were complimentary of the staff.

We found a number of 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 always safe.

Medicines were not stored within the correct temperature range.

Measures intended to safeguard against the risk of Legionella were not fully implemented.

Staff knew how to recognise and address any concerns of abuse, accidents and incidents and risks were managed appropriately.

People were supported by enough staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Deprivation of Liberty Safeguarding authorisations had not been applied for when warranted.

Mental capacity assessments did not always meet with the requirements of the Mental Capacity Act 2005.

People were supported to eat and drink when needed and they enjoyed the variety of food provided.

Training and supervision for staff had been carried out regularly and was effective in practice.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and were considerate of their dignity, and were observed engaging with people in a kind and gentle way.

People were encouraged to be independent where possible and were given choices about their care and support.

People's families and friends were able to visit at any time and were made welcome.

Care records and information about people was treated confidentially.

Is the service responsive?

Good

The service was responsive.

Care plans were updated to reflect people's current needs.

Changes in health or social needs were responded to. Short term care plans were written for people with acute conditions.

The home a dedicated activity coordinator and people told us they enjoyed the activities provided.

There was a complaints procedure available for people and their representatives should they be unhappy with any aspect of their care or treatment.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits and quality assessments were not wholly effective in identifying shortfalls within the service.

Staff felt supported. They were aware of the service's values and behaviours and these were followed through into their practice.

People, their relatives and staff thought the service was well run and spoke positively about the leadership of the registered manager.

There was an open and transparent culture; people and staff felt encouraged to speak up with suggestions and concerns.

Mandalay 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 registered persons were 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.

We undertook an unannounced inspection of this service on 21and 22 April 2016. The inspection was undertaken by one inspector.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met and spoke with 11 people who lived at Mandalay Care Home and observed their care, including the lunchtime meal, medicines administration and activities. We spoke with five visiting relatives, a visiting health care professional and a social care professional. We inspected the environment, including the laundry, bathrooms and some people's bedrooms. We spoke with four care workers, kitchen staff, a volunteer entertainer, the activities coordinator as well as the deputy manager and registered manager.

We 'pathway tracked' three of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We also looked at care records for four other people.

During the inspection we reviewed other records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe, were happy at Mandalay Care Home and thought there were enough staff on duty to support them. Visitors commented positively about the staff and registered manager. One person told us," I am very happy here, I haven't seen or experienced anything to cause me not to be and I don't think I will, I feel safe and reassured by the staff". Another person said, "I do feel safe here. I feel better in myself because I don't worry anymore about being on my own or without help if I fell or was unwell". A relative commented, "I have no concerns or pangs of doubt when I leave mum after visiting, I know she is safe and well looked after". Another visitor told us "I would have no hesitation about coming to live here personally. A visiting health care professional also commented positively about the service, accessibility of staff and the care people received.

Our last inspection found the service was not always safe and required improvement because risk assessments and care plans varied in detail; they did not always provide enough guidance to ensure people received support safely and consistently. We asked the provider to take action to make sure these concerns were addressed. During this inspection we found the provider had improved in this area. However, the way in which medicines were stored meant the service was not always safe.

Non refrigerated medicines need to be stored at temperatures not exceeding 25°C, this is because storage above this temperature risks medicines becoming desensitised, not working as intended or potentially ineffective. Although the service had fitted extractor fans to the medication room in an effort to manage its temperature, records showed excessive temperatures continued to be a problem and had been an issue for more than two years. Measures introduced to mitigate the risks of spoiled medication because of excessive storage temperatures were ineffective.

People were at risk associated with the unsafe management of medicines. This was a breach of Regulation 12 (1)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Otherwise, medicines were ordered, administered and disposed of safely. They were stored securely in a designated, locked room and administered from lockable trollies. Staff had a clear understanding of people's medication. They commented they felt confident in administering medicines and demonstrated an awareness of any side effects. We observed medicines being given to people, spoke with staff who gave them out and people who received them. People told us they received their medicine on time and knew what it was for. Staff were considerate and patient when administering medicines, people did not appear rushed or pressured.

Assessments had been made about risks associated with people's medicines; including whether people were able to self-administer their tablets and creams. Information was held for each person about how they took their medicine and their ability to express their need for medicines. These documents gave staff important guidance about individual people's needs and preferences and also about how different people communicated pain. If people had difficulty swallowing, where possible, medicines were provided in liquid form. In some cases medicines were administered covertly without people's knowledge. In these cases

proper consultation processes were followed and professional agreement gained, together with advice from the supplying pharmacist to make sure medicines were safe to be administered in a different way. For example, by crushing pills and mixing them with drinks or food.

Safety checks had been carried out and recorded for all equipment and services, including hoists, passenger lifts, gas and electrical systems and most water temperatures. However, arrangements set out in the services' water management policy to safeguard against the risks of Legionella, a waterborne bacterium, were not fully met. Although surveys were commissioned, sample water tests undertaken and pipework flushed, checks did not take place to ensure water was heated and circulated at temperatures prescribed within the policy. Any bacteria present multiply where temperatures are between 20-45°C and nutrients are available. The bacteria are dormant below 20°C and do not survive above 60°C. Legionnaires' disease is a potentially fatal type of pneumonia, contracted by inhaling airborne water droplets containing viable Legionella bacteria. We recommend that Legionella water temperature control measures are undertaken and recorded as set out in the services' policy.

Individual risk assessments were completed and reviewed when needed. Staff were knowledgeable about the people they supported and familiar with risk assessments. These included medication, eating, drinking and risks of choking as well as use of equipment such as pressure reducing mattresses, lifting aids and wheelchairs. Incidents and accidents were recorded and analysed. They were used to look for any patterns or trends and to inform learning and care plan reviews. This helped to minimise the risk of incidents happening again. Where needed input had been sought from other professionals, such as the GP, psychiatric services and pharmacists to help resolve any problems identified.

There were sufficient staff with a suitable mix of experience and skills to meet people's needs in both the main house and the Sunflower unit. In total, daytime staffing comprised of five care staff and two senior carers in addition to two deputy managers and the registered manager. Four waking staff night support. Staffing allocations ensured a senior carer was always on duty on each shift. Other staff undertook duties such as housekeeping and maintenance. A chef provided meals supported by a kitchen assistant; the service employed a coordinator to organise and facilitate activities. Any staff shortfalls were met through use of existing staff to help to ensure consistency of care. Risk and needs assessments formed the basis to determine how many staff were needed. Discussion with the registered manager and a review of staffing records demonstrated staff deployment was a flexible system allowing for additional staff when needed.

People and relatives told us they were satisfied with staffing levels. We spoke with people about how long it took staff to come to their bedroom if they pressed the call bell or if they needed help around the service. People were confident staff would come when called, no one told us they felt they had to wait for too long. The registered manager carried out checks of call bell response times and other spot checks to ensure staff completed specific tasks. Observation throughout the inspection found staff were aware of people's support needs and people received appropriate support.

Any concerns about people's safety or wellbeing were taken seriously. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. Policies ensured staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed all care staff had received safeguarding training and any safeguarding referrals were made when needed.

Environmental safety audits highlighted any hazards or repairs needed throughout the service and records confirmed these had been signed off as completed promptly. We walked around the service and looked at most areas of it. Many areas were recently decorated and new floor coverings fitted in the lounge. People,

visitors and staff commented positively about the upkeep of the service and the improvements made. One visitor told us "I have noticed an improvement and investment in the décor and gardens". A maintenance planner scheduled any remaining work for completion.

People were protected from fire and other urgent risks. Personal emergency evacuation plans were in place for each person and included information about individual support needs. Numbers of staff needed to assist people and any equipment required, such as a wheelchair or walking frame were also documented. There was an emergency plan in place for major incidents which had been recently reviewed. Fire alarm testing was carried out weekly and fire drills were recorded.

Requires Improvement

Is the service effective?

Our findings

We spent time talking with people, their relatives and visiting health and social care professionals about the quality of care provided; all comments made were positive. Where people were unable to communicate with us, we observed their interaction with staff and the care delivered. People told us they felt staff understood their needs and had confidence in the staff who supported them. Comments included "I couldn't wish for better staff" and "Staff know how to support me and they do it in a way that shows they want the best for me. They always do their best, that's what makes them good and I like that". A visitor told us "I feel my mother is cared for well, she is in good hands". People and their relatives said staff usually communicated with them well, although on some occasions visitors told us they were not always updated as quickly as they would like to be, for example, if their relative was unwell or admitted to hospital.

Our last inspection found the service was not always effective and required improvement because people were not properly supported to make choices about what they ate and there was a lack of communication when supporting people. We asked the provider to take action to make sure these concerns were addressed. During this inspection we found the provider had improved in this area. Comments received about the quality of care provided and our observation of care delivered were positive; however, there were aspects about how people's capacity to consent was assessed and some restrictions in place which meant the service was not always effective.

CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS), which form part of the Mental Capacity Act (MCA) 2005. It aims to make sure people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep people safe. Where restrictions are needed to help keep people safe, the principles of DoLS should ensure that the least restrictive methods are used and are subject to appropriate authorisation.

The MCA requires providers to submit DoLS applications to a 'Supervisory Body' for authority to impose restrictions where people are unable to consent to them. These can include, for example, the use of bedrails, consent to receive care and treatment in a residential service, being confined to certain areas of the service, being the subject of continuous supervision within a service or when outside of the service. There were examples of these restrictions in place for some people.

Records showed five people with no capacity, 23 people with varying capacity and 12 people who had capacity. One of the basic principles of the MCA is that people should be presumed to have capacity unless appropriate assessment determines they have not. Assessments of people's mental capacity should be about specific decisions; record the steps taken to reach a decision; or any measures taken to help people form their own decisions. Some of the mental capacity assessments seen were not decision specific and did not include reference to the points outlined above. Therefore they did not meet the principles of the MCA.

Additionally, a lasting power of attorney (LPA) a legal document that lets a person appoint one or more people to help make decisions or to make decisions on their behalf. If an LPA is in place, appropriate

evidence should be held to confirm that an appointee can make decisions on another person's behalf; some LPA's are for finances only and would not entitle the holder to make decisions on health or welfare matters. The service did not always hold confirmation of LPA, yet decisions had been made on the basis that an LPA was appointed; potentially people's rights were not protected because some decisions may have been made by parties not legally entitled to make them. The service recognised further work was required around LPA's and the registered manager planned an exercise to validate the information they held.

No applications had been made to the local authority for people who lacked capacity to consent to receive care and treatment at the service or who were subject to other restrictions. The service did not demonstrate an embedded understanding or practices which met the principles of the MCA 2005. This is a breach of Regulation 11(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Otherwise, particularly in relation to day to day decisions, staff were aware of the basis of the MCA and how to support people who did not have the capacity to make a specific decision. We heard staff encourage people to take their time to make decisions and staff supported people patiently whilst they decided. Policies reflected that where more complex or major decisions needed to be made, involvement of relevant professionals such as GP's and an Independent Mental Capacity Advocate was required. Advocates are people who are independent of the service and who support people to make and communicate their wishes. Information about these processes was available to people and visitors within the service. We saw examples where the advocacy service had been used.

Each person had a health care plan. This set out their initial assessment when they arrived at the home and regular, subsequent reviews charted changes in their health needs and ongoing support needed. Care staff were knowledgeable about the people they supported, their specific health needs and how the needs should be met. Where needed, the service sought input from social and health care professionals such as the community psychiatric team, speech and language therapists and occupational therapists. This helped to ensure people received the right help to support any emerging needs. People told us they saw their GP when they needed to and felt their health care needs were being met.

Relatives were satisfied with the health care people received at the home. Chiropodists, dentists and opticians visited the home when people needed them. The registered manager recognised the importance of seeking expertise from community health and social care professionals so people's health and wellbeing was promoted and protected. One person spoke with us about how life had been for them at Mandalay Care Home after leaving their home and their subsequent move to the service. They felt staff had supported and encouraged them to regain their confidence and physical health so that they could "enjoy life again". Where people needed more specialised support, for example pressure relieving mattresses to help reduce the risk of skin damage, or oxygen to help people with their breathing, suitable equipment and checking processes were in place.

Staff spoke positively about training received and were able to tell us how they used it in their day to day role, for example, in relation to skin care to reduce the risk of pressure areas. People told us they trusted the staff, thought they were well trained and knew how support them. One person commented, "All the staff are good at their job". New staff members told us and training records confirmed they were required to complete the Care Certificate induction programme and were not permitted to work alone until they had been assessed as competent in practice. The Care Certificate is an identified set of standards that social care workers should keep to in their daily working life. Other training for new staff included some class room based sessions, shadowing experienced staff, written assessment workbooks and observational assessments of competency. This helped to ensure staff had understood what they had been taught and could apply their training in practice. Staff said they felt supported thorough their induction period.

There was an established programme of on-going training for staff. Training records and certificates confirmed the training undertaken. The training plan identified when essential training, such as fire safety, health and safety, manual handling and safeguarding required updating. Staff training included other courses relevant to the needs of people supported by the service such as dementia, challenging behaviour and diabetes awareness. Care staff were encouraged to carry out formal training in health and social care, such as vocational qualification training or diplomas to levels 2 or 3. Staff rotas confirmed the service gave appropriate consideration to the skill mix of staff when planning the various shifts. This helped to ensure people's needs could be effectively met.

Staff supervision took place regularly in addition to informal discussions to keep up to date with any changes. Supervisions included discussions about previous action plans, the job role, working relationships, reviews of training and personal development plans. Staff said this gave an opportunity to talk about any concerns, think about their development and receive support to achieve their goals. The supervision process enabled the registered manager to maintain oversight and understanding of the performance of all staff to ensure competence was maintained. This helped to ensure clear communication and expectations between managers and staff. Supervision processes linked to disciplinary procedures where needed to address any areas of poor practice, performance or attendance. Although overdue, processes were underway for annual appraisals to take place with initial stage self-appraisal forms having been provided to staff for their completion.

We observed the service of lunch. People who were too frail to come to the dining area or preferred to eat in their rooms were supported by staff. Staff engaged positively and cheerfully with people; they provided people with appropriate assistance in a sensitive manner and chatted with the people they supported. People were offered a choice of drinks, hot or cold; staff encouraged people to drink to reduce the risk of dehydration.

People received a wide variety of homemade meals and told us fresh fruit was available each day. The chef was enthusiastic, conscientious and took pride in all aspects of his role, but particularly the importance of people receiving nutritious food in a way that they could safely eat and was enjoyed. Home baked cakes, biscuits and desserts, were popular and people told us they appreciated the efforts of the kitchen staff. The chef spoke with people about their food preferences and asked what they thought about their meals. This ensured they received direct feedback about the food they provided.

People told us they enjoyed the food and spoke well of the choices offered to them. One person said, "The meals are delicious, we get a good choice every day." Another person told us if they did not like what was offered to them on the day, they could always have something else that wasn't on the menu. The chef catered for people with a range of dietary needs including diabetic, softened and vegetarian options. The kitchen area was clean and well managed with food and utensils stored appropriately; the Environmental Health Authority had awarded the kitchen a five star rating, this being the highest standard. Relatives sometimes stayed for meals and said the food tasted good, was plentiful, but not so much as it was overwhelming and looked appetising.

Good

Is the service caring?

Our findings

People were cared for in a kind and compassionate way. Staff respected and treated them as individuals and people said they were happy and appeared content in the home. One person said, "I always find the staff kind and caring." Another person told us "Staff are wonderful, they are gentle and kind". A relative commented about their father, saying, "Staff treated him with real affection". We spoke with a family who had recently suffered the loss of their relative. They told us "Staff treated her as a member of the family. In the last few hours, they couldn't have done any better; they went an extra two miles". Another visitor commented that their relative "Never appeared gloomy or unhappy", while a further relative told us their mother was "Always well turned out; her hair was brushed and her finger and toe nails were trimmed and clean". People told us staff listened to them and acted on what they said and this was evident from our observations during the inspection.

Staff were clear about how to treat people with dignity, kindness and respect. Staff used effective communication skills which demonstrated knowledge of people and showed them they were thought of and treated as individuals. For example, staff spoke with people at the same level so it was easier to communicate with them or to understand what was being said. They made eye contact and listened to what people were saying, and responded according to people's wishes and choices. Staff told people what they were doing when they supported them. They gave some people a narrative, such as your lunch has arrived, tell me what you would like to drink and would you like me to assist you. This respectfully helped people to make decisions and introduced orientation to any support they might need. Staff were courteous and polite when speaking to people in private. They gave people time to respond and spoke in a way that was friendly and encouraged conversation.

Staff showed attention to the details of care, people's hair was brushed; they were helped with nail care, jewellery or make-up, or assisted with shaving. Clothes were clean and ironed. This level of care helped to demonstrate that staff valued and respected the people they supported. Visitors confirmed they found staff knowledgeable about the support their relative needed. They commented that whenever they visited, people seemed well cared for and happy. People were supported to maintain important relationships outside of the service. Relatives told us there were no restrictions on the times they could visit the service, they were always made welcome and invited to events. Staff recognised people's visiting relatives and greeted them in a friendly manner and offered them drinks. Visitors told us they could speak to people in private if they wished and gave positive comments about how well staff usually communicated with them, for example, about changes in people's health.

Staff knew people well and demonstrated a high regard for each person. Staff spoke with us about the people they cared for with genuine affection and were able to tell us about specific individual needs and provide us with a good background about people's lives before living at the service; including what was important to people. People were addressed by their preferred name and staff took the time to recognise how people were feeling when they spoke with them. For example, one person became agitated. Staff touched their hand and spoke calmly and slowly with the person, encouraging them to speak and help them understand why they were unhappy. Staff knew how to reassure the person, they chatted and this helped to

calm the person. However, when another person became confused about whether their son was visiting, two members of staff each told the person different things. This further confused and unsettled the person. Staff were reminded to be consistent in their approach when supporting people.

Care plans recorded details of end of life care arrangements, when needed; this was provided in conjunction with local nursing and hospice services. The service had adopted a system of 'Just in Case' boxes to support anticipatory prescribing and access to palliative care medications, for people who were approaching the end of their life. People often experience new or worsening symptoms outside of normal GP practice hours. The development of 'Just in Case' boxes seeks to avoid distress caused by poor access to medications in out of hours periods. This is done by anticipating symptom control needs and enabling availability of key medications in the service. Visitors told us staff had continually checked a person receiving end of life care, ensuring they were comfortable and addressing any needs with dignity and compassion. The registered manager told us a member of staff would always sit with a person in their final hours. Staff had made remembrance cards for people who had recently passed away; they had signed them and were available for people to add their own messages and tributes. Funeral arrangements were discreetly available and staff and people could be supported to attend if they wished. During our inspection a family called at the service to arrange an after funeral buffet to be held at Mandalay Care Home for their relative who had lived at the service.

People's care plans showed that discussions took place at the time of admission to ask if their family members wished to be contacted in the event of any serious illness or accident. We saw where needed, this had usually happened. Some people who could not easily express their wishes, or did not have family and friends to support them to make decisions about their care, were supported by staff and an advocacy service.

People's privacy and dignity was protected. Staff knocked on people's doors and tended to people who required support with personal care in a dignified manner. Care records were mainly held on computers, this was secure and information was treated confidentially. Staff had a good understanding of privacy and confidentiality and there were policies and procedures to underpin this.

Good

Is the service responsive?

Our findings

People told us they felt staff were responsive and supportive to their needs and were offered choice in all parts of their care. One person told us, "I get offered choices and decide my own daily routine." A visitor commented of their late father, "He was happy here, he kept his own routine of getting and going to bed, if he was up late he would often chart with staff". Some people told us "I like to stay in my room and keep my own company". Other people told us they enjoyed the activities and liked to join in. Throughout our inspection people were being cared for and supported in accordance with their individual wishes.

The service had invested in technology, all care plans were computer based. Staff accessed and updated records using hand held tablets. The system afforded the registered manager at a glance information and reminders when events were due. The system was fully supported by an IT service and they worked in conjunction with the staff to develop and enhance the system. Back up paper files were maintained with select important information for ease of reference and emergency use.

People had the opportunity to be involved in the assessment of their needs and preferences as much or as little as they want to be. Pre-admission assessments were completed from the outset to ensure the service could meet people's individual needs and that prospective residents were suited to the service. Examples were given where people had not been admitted to the service because their needs or behaviours could not be safely met and may have disrupted other people.

Admission assessments included all aspects of people's care, and formed the basis for care planning after people moved to the service. The service maintained and met a target that care plans would be in place for any new admissions, including short term respite care, within 48 hours. Each person had a care plan. Their physical health, mental health and social care needs were assessed and care plans developed to meet those needs. Care plans included information about people's next of kin, medication, dietary needs and health care needs. They were comprehensive, had been reviewed monthly or as required and were up to date. Individual needs and preferences were established and care and support was tailored to meet them.

Changes in health or social needs were responded to. Short term care plans were in place for people with acute conditions for example chest and urinary infections. Other examples included assessments and care plans drafted with the support of mental health services where a person's behaviour had changed. Where weight loss was noted for another person, an action plan also ensured relevant external bodies had been consulted such as their GP and a dietician. Where advice and instruction was received from health care professionals, such as District Nurses, these directions were put into practice. A visiting health care professional told us staff took on board what they said and acted accordingly. They did not raise any concerns and felt that communication within the service was good. This showed evidence of staff being responsive to the changing needs of people who lived at the home.

An activities timetable was displayed in a communal area. Some of the activities listed included quizzes, puzzles, armchair exercise, outings, visits to the local park and visiting musicians. Activities were happening for most parts of the day apart from mealtimes. We observed people engaging in seated exercise sessions

and playing board games with staff and listening to a guitarist visiting the service. There was much laughter during these activities and people told us they enjoyed spending time with one another and staff. Daily activities records were kept for each person; to show what they had been doing and whether they enjoyed it. The service celebrated people's birthdays as well as national events. For example, our visit coincided with the Queen's 90th birthday; staff had put up union jack bunting and were holding a tea party that evening to celebrate. People told us they were looking forward to this, together with the cakes the chef had made especially for the occasion. Some people did not leave their rooms to join in with organised activities and staff told us the activity coordinators visited these people to have one-to-one chats if they wished to try to prevent people from becoming socially isolated.

People were supported to stay in touch with family and friends. The service organised outdoor summer events held in the service and garden. People were encouraged to have visitors to stay for meals.

The service had a complaints procedure, which was available to people and visitors to see. It was also included in the information given to people and their relatives when they moved to the service. The procedure was clearly written; it contained details of different contacts and also advised people that the service would find an independent advocate if anyone needed help to complain. There was an 'open door' policy and the registered manager made themselves available to people and their relatives, this was evident during our inspection and commented upon positively by visitors we spoke with. There was a system for people to write down any concerns and staff told us how they would support people doing this. Documentation showed that all concerns and complaints were taken seriously, investigated, and responded to in a timely way. People were confident they could raise any concerns with the staff or the registered managers and said they would not hesitate to complain if they needed to. At the time of the inspection, the service was not dealing with any complaints. Where lessons could be learnt from previous complaints, effective systems ensured key messages were passed on to all staff. This helped to prevent complaints from reoccurring.

Requires Improvement

Is the service well-led?

Our findings

People and visitors were complementary about the manager and staff, commenting positively about how approachable they were. People told us they felt staff made time for them. Relatives and visitors to the service told us they were made to feel welcome and referred to the registered manager as knowledgeable and supportive.

Auditing and checking procedures were in place within the service. The registered manager and key staff undertook regular checks of the service to make sure it was safe and people received the support they needed. These included areas such as infection control, mattress condition audits, medicine management, nutrition, mobility, care plan quality and maintenance. Previously, additional quality assurance checks were carried out at the service on behalf of the provider, however, these stopped when staff fulfilling that role left the organisation. Their position remained vacant at the time of the inspection; provider quality assurance checks had not taken place in the current year. The concerns identified during this inspection illustrated the quality assurance framework in at the service was not fully effective. This was because it had not recognised or put measures in place to resolve areas where regulations were breached. These include ensuring DoLS applications were made where needed, medicines were stored within the required temperature range and Legionella preventative measures were fully implemented in line with the services' policy. Therefore, systems had not ensured continuous oversight of all aspects of the service.

The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services was a breach of Regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Established systems sought the views of people, relatives, staff and health and social care professionals. Regular meetings and a suggestions system ensured people and their families felt involved in the service and listened to. Where people had made suggestions, these were well received and acted upon. Staff felt the provider and registered manager listened to their opinions and took their views into account. For example concerns about people receiving other people's laundry back had been addressed, a new system was in place and people were satisfied with this.

Staff told us and records confirmed the culture within the service was supportive and enabled staff to feel able to raise issues and comment about the service or work practices. Staff generally commented about the open culture at the service and felt able to speak out about anything. Staff told us, if needed, they felt confident about raising any issues of concern around practices within the service and felt they would be supported by the registered manager.

The service has a philosophy of care which was given to people when they came to live at the service. The registered manager told us the values and commitment of the service were embedded in the expected behaviours of staff; these were discussed with staff and linked to supervisions and appraisals. Staff told us the values and behaviours included treating people as individuals, being respectful, teamwork and making the most of people's strengths to live a fulfilled and independent life. Staff understood the values of the

service and could see how their behaviour and engagement with people affected their experiences living at the service. Staff displayed these values during our inspection.

People knew the different roles and responsibilities of staff and who was responsible for decision making. Observations of staff interaction with each other showed they felt comfortable with each other and there was a good supportive relationship between them. Staff felt they worked together to achieve positive outcomes for people, for example, discussing outings or the health of a person who was agitated and suggested actions.

Policy and procedure information was available within the service and, in discussion; staff knew where to access this information and told us they were kept informed of any changes made.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users must only be provided with the consent of the relevant person. Where people were unable to give such consent because they lack capacity to do so, the registered person had not acted in accordance with the 2005 Act. Regulation 11(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk associated with the unsafe management of medicines because they were not stored within the specified maximum temperature. Regulation 12 (1)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure appropriate systems or processes to assess, monitor and improve the quality and safety of services were in place. Regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.