T.L. Care Limited

Mandale Care Home

Inspection report

136 Acklam Road, Thornaby, Stockton on Tees, TS17 7JR
Tel: 01642 674007

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Inadequate
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

We inspected Mandale Care Home on 13 and 14 November 2014. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting. We last inspected the service on 6 November 2013 and found the service was not in breach of any regulations at that time.

Mandale Care Home is registered to provide personal care and accommodation, diagnostic and screening procedures and treatment of disease, disorder or injury, for up to 57 older people, some of whom may be living with a dementia. At the time of our inspection visit the home had 13 vacancies. The service is provided by TL Care Limited which is operated by the Hillcare Group. The home is purpose built and is set up over two floors, accessible by both stairs and a passenger lift. The ground floor offers residential care with the first floor offering dementia care.

The registered manager had been registered with CQC since January 2013. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of the inspection we found that the home was not providing nursing care to people who lived at the

Summary of findings

home. The registered manager confirmed that the home had not provided nursing care for a number of years. We discussed with the registered manager the importance of ensuring that the service held accurate registration in relation to regulated activities and advised them of the need to apply to deregister the regulated activities that they were no longer carrying on.

Care records we looked at demonstrated that the needs of people who used the service were subject to initial and on-going assessment. We saw that these assessments accurately captured the needs of people and were used to plan and deliver effective and appropriate care. Where appropriate risk assessments were completed, identifying risks and the measures in place to ensure that people were protected from the risk of harm. We saw that where appropriate, for example where people's assessed care needs had changed, staff made referrals to other healthcare professionals to ensure the correct level and type of care could be delivered.

Our observations over the two days demonstrated that, in the main, people were supported by sufficient numbers of staff. We saw that staff were respectful of people when they delivered care and support and acted in accordance with the wishes of individuals. On the first day of the inspection we did raise concerns with the registered manager and the regional manager about the chaotic atmosphere over lunch time on the first floor and the negative impact that this had on the mealtime experience for these people. On the second day of the inspection we were informed by the registered manager that the usual lunchtime routine had been amended and from our observations we saw that staff were more visible, people who used the service were calm and there was a very relaxed atmosphere.

People we spoke with told us that they felt safe living at the service. They told us that they felt they received good care and that the staff were very kind and respectful. Staff spoke very confidently about the procedures they would follow to take action to ensure the safety of people if they suspected someone to be at risk of harm or abuse.

Staff did not understand the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards which meant they were failing to work within the law to support people who may lack capacity to make their own decisions.

Appropriate checks of the building and maintenance systems were undertaken to ensure risks to people's health and safety were minimised.

We looked at staff employment files and found that they were subject to rigorous pre-employment checks before they commenced work. When we spoke with staff they informed us of the checks that were carried out and the induction and training process they undertook when they took up employment. Staff told us that they were always completing training and that they felt well supported. From a review of training records we found this to be the case.

Staff we spoke with spoke with knowledge about the care needs of people that they helped to support and care for. We found that the staff knowledge of people's needs was corroborated by care records and from observations we carried out.

We found that people who used the service were provided with information about how they could raise any concerns and complaints as necessary. We found people's concerns were responded to appropriately by the registered manager and there were systems in place to enable the service and the provider to learn from complaints and incidents.

The service had a process for monitoring and assessing the quality of the service provision but we were unable to assess its effectiveness due to issues being repeatedly identified and highlighting a failure to produce action plans to address those issues.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People living at the service told us they felt safe. Staff were clear on what constituted as abuse and had a clear understanding of the procedures in place to safeguard vulnerable people and how to raise a safeguarding alert.

Staffing levels were appropriate. Robust recruitment procedures were in place and appropriate checks were undertaken before staff started work.

People's medicines were managed so that they received them safely. There were appropriate arrangements in place for ordering, obtaining and checking medicines upon receipt into the home.

Is the service effective?

Inadequate

The service was not effective.

Staff attended training relevant to the needs of the people who used the service and were supported by management through a supervision and appraisal process.

Consent to care and treatment was not always sought in line with legislation and guidance.

People had access to healthcare services and received on-going healthcare support. External healthcare professionals were involved in the on-going assessment of people's needs when appropriate.

We found that people were supported to have sufficient to eat, drink and maintain a balanced diet. Care was not taken to ensure that mealtimes were enjoyable experiences for those people who used the service.

Is the service caring?

Good

The service was caring.

Positive and caring relationships were developed with people who used the service. The service had a stable staff team who had taken time to get to know the people who used the service. Observations demonstrated that people were treat with kindness and compassion.

People's privacy and dignity was respected and promoted. Staff were discreet in their approach to offering care and support to people who used the service.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support. Care records demonstrated that people had been involved in development of care plans. People had expressed wishes in relation to the delivery of their care and staff demonstrated knowledge and understanding of these preferences.

Summary of findings

Is the service responsive?

Good 

The service was responsive.

People received personalised care that was responsive to their needs.

Planning and delivery of care and support was person centred and focused on assessed needs. They were subject to regular review to ensure care remained responsive to the needs of the people who used the service.

The service routinely listened and learnt from people's experiences, concerns and complaints. The service had a complaints procedure in place that was made available to people who used the staff. Staff demonstrated a good understanding of the procedures around receiving complaints, concerns and experiences.

Is the service well-led?

Requires improvement 

The service was not well-led.

The service promoted a positive culture that was person-centred, open, inclusive and empowering. They achieved this by ensuring that people who used the service and staff had opportunities to suggest ways in which the service could be improved.

The service had a process for monitoring and assessing the quality of the service provision but we were unable to assess its effectiveness due to issues being repeatedly identified and failure to produce action plans to address those issues.

Mandale 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.

We inspected the home unannounced over two days, 13 and 14 November 2014. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting.

The inspection team consisted of a one adult social care inspector 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. The expert by experience had experience of services that provided care and support to older people some of whom may be living with a dementia.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also spoke with the responsible commissioning officer from the local authority commissioning team about the service.

The provider was not asked to complete 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.

At the time of our inspection visit the service was occupied by 44 people, with 20 people receiving dementia care and 24 people receiving residential care. The inspector and the expert by experience spent time on each of the floors talking to people who used the service, visitors to the home and staff. With the permission of individuals we looked in people's bedrooms, we also spent time in and viewed all other areas / facilities within the home including bathrooms and all communal areas.

During the inspection we reviewed a range of records, including care records, care planning documentation, medication records, staff files, including staff recruitment and training records, records relating to the management of the home and a variety of policies and procedures developed and implemented by the provider.

On each of the two days we visit we carried out a Short Observational Framework (SOFI) over the lunch time period. SOFI is a tool that we use to observe and help us understand the experiences of people who are living with a dementia and who are unable to recall specific memories and events or may be unable to communicate with us verbally.

During the visit, we spoke with 14 people who used at the service, 4 relatives of people who used the service, 10 staff members, including a unit manager, cook, cleaner, and five care assistants. We also spoke with the registered manager and the regional manager of the service.

Good

Is the service safe?

Our findings

We spoke with staff about their understanding of protecting vulnerable adults from abuse. Staff demonstrated good knowledge and understanding of safeguarding procedures and they demonstrated that they were able to identify types of abuse and spoke confidently of the procedures they would follow if they had any concerns. The service had policies and procedures in relation to the safeguarding of vulnerable adults. These documents were accessible to staff.

People we spoke with told us that they felt safe living at the home. One person told us, "100% I feel safe here", and, "Staff are very nice and friendly and they are respectful." Another person said, "I do keep my privacy and independence."

The service used a dependency assessment tool, based on the assessed needs of those people who used the service, to determine the minimum staffing levels required. We saw that this was subject to regular review. We looked at 12 weeks of duty rotas (this incorporated eight weeks leading up to the inspection and four weeks that were planned) and found that staffing levels were in line with the outcome of the dependency assessment tool.

Staff told us that they felt there was sufficient staff and support available on each shift. One member of staff told us that the manager had responded positively to concerns raised by staff recently about the staffing levels on the residential unit. They told us this positive response included increasing staffing levels from three to four members of staff. This same member of staff did say that they had concerns about the night shift staffing levels and whether or not they were appropriate. We spoke with the registered manager about this and they confirmed that night shift staffing included four members of staff. We saw that these staffing levels were in line with the dependency assessment outcome, but the manager did advise they would explore the concern with staff. When we asked people who used the service about staffing levels and availability they did not raise any concerns in their discussions with us. One person said, "They (staff) are very good, very attentive."

We saw that there were effective recruitment processes and checks in place to ensure safety and suitability was explored prior to offering employment to staff. We saw that the provider had a recruitment policy and that in line with that policy, checks to ensure people were safe to work with vulnerable adults, called a Disclosure and Barring Check, were carried out for any new employees. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. We looked at the recruitment records of four members of staff who had been recruited to the service in the past 12 months. There were checks on their identity, references from previous employers and details of the interview process in place. We saw that each of these members of staff had completed an induction prior to working unsupervised in the service.

We found that people's medicines were managed so that they received them safely. We saw that there were appropriate arrangements in place for ordering, obtaining and checking medicines upon receipt into the home. Adequate stocks of medicines were securely maintained to allow continuity of treatment and medicines were stored in a locked facility. Medicines were managed by designated staff members, namely senior care assistants. When we spoke with these staff they spoke with confidence about the procedures that they followed in relation to medicines management and described the ordering, checking, administering and disposal processes.

We saw that accidents and incidents were recorded by staff and reported to the registered manager. This information was then analysed by the registered manager on a monthly basis to determine if any trends had been identified. The analysis we reviewed demonstrated that where risks to people's safety was identified, action was taken to minimise the risk of recurrence. For example, we saw that where people had experienced a number of falls referrals were made to other professionals and additional monitoring, such as safety checks, were put in place.

The service had considered emergency events and had made plans to ensure the safety of people who used the service in the event that an emergency should arise. We saw that personal emergency evacuation plans (PEEPS) were in place in each of the four sets of care records we looked at. PEEPS provide staff with information about how they can ensure individuals safe evacuation from premises in the event of an emergency.

Good

Is the service safe?

We spoke with the registered manager and looked at records which confirmed that checks of the building and equipment were carried out to ensure health and safety. We saw certification and documentation that identified relevant checks had been carried out on the boiler, water tanks, fire extinguishers and portable appliance testing (PAT) available throughout the service. We also saw that there was a maintenance log which staff could report maintenance issues in. We saw that issues raised in this log were actioned in a timely fashion by the maintenance person in order to minimise any potential risks they may pose to people who used the service. This showed that the provider had developed a maintenance system to protect people who used the service against the risks of unsafe or unsuitable premises.

Inadequate

Is the service effective?

Our findings

We saw that staff had received training to ensure that they were appropriately trained to deliver effective care to people who used the service. For example, at the time of the inspection we saw that over 97% of staff had completed training in the following areas; moving and handling, health and safety, infection prevention and control, dementia awareness, medication and food hygiene.

We saw that there were gaps in completion of the following training areas; nutrition, continence care, safe use of wheel chairs, safe use of bed rails and pressure area care. However the manager had made arrangements to ensure that staff attended these outstanding training areas with courses booked throughout November and December. We also saw that other training needs had been identified such as depression and end of life care.

We spoke with the manager about the additional training needs they had identified. They confirmed that they had been identified as a direct result of the assessed needs of people who used the service and were being provided to ensure staff held a greater understanding of these needs.

We found that staff received regular supervisions and annual appraisals. These processes were used to discuss with staff areas for their professional development. We saw that a number of staff had enrolled on or completed additional vocational training. Staff told us that they felt very well supported by the registered manager and the provider. They told us training was always on offer and that this was one of the reasons that the remained at the service. This meant that people who used the service received effective care from staff that had been supported and encouraged to improve their knowledge and skills needed to deliver good, effective care.

We reviewed a sample of four sets of care records and saw documentation that showed us people's health and social needs were assessed before they moved into the service. This was done to help ensure that people's care and support was appropriately planned and could be delivered effectively.

On the first day of our inspection we were informed that staff had identified deterioration in the health and well-being of one person. We observed that staff contacted external healthcare professionals, the GP was contacted and visiting arrangements were made, with staff taking instructions in the interim period to ensure effective care and monitoring of the person was in place. From our observations we saw that the care and support delivered to people was in accordance with the recommendations made by external healthcare professionals. This meant that the service had identified changes in people's needs and took action to ensure they could continue to meet their needs effectively.

We looked at whether the service was applying the Deprivation of Liberty safeguards (DoLS) appropriately. These safeguards are designed to protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed and is lawful. We found that the service were in the process of completing a number of these applications following a recent visit from the local authority. We asked about capacity assessments that would accompany these applications and were informed by the registered manager that assessments had not been completed. We saw in one person's care records that they had a history of self-neglect. We reviewed these records to determine if a capacity assessment had been completed to enable best interest decision making. We saw that no capacity assessment had been completed in relation to this particular area. We did see evidence in another person's care records, that capacity had been considered to a degree within a care plan entitled, 'Mental Awareness'. This demonstrated that people were assumed to lack capacity because of their dementia. Statements included, 'due to his dementia, X is unable to do anything for themselves or make decisions'. This goes against the fundamental principles of the Mental Capacity Act 2005 which assumes capacity until appropriate assessment proves otherwise.

In another set of care records there was a partially completed mental capacity assessment. We could not determine what the assessment related to, i.e. the nature of the decision that needed to be made, as the form was blank. There were no details of how the test had been applied, no outcome of the assessment or details of the best interest decision that might need to be made.

Inadequate

Is the service effective?

In discussions with staff we were told that new mental capacity documentation had recently been inserted to care plans but that they felt uncomfortable completing it as they did not feel that the training they had undertaken equipped them to do so.

This was a breach of Regulation 18 (Consent to Care and Treatment), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that 95% of staff had completed Mental Capacity Awareness Training.

Our observations demonstrated that verbal consent was obtained by staff before they engaged in any care or support interactions. We saw staff approach people and explain to people what they would like to do to offer support before confirming with them that this was okay.

We saw that a mid-morning drinks, biscuits and snacks were provided to people who used the service. Staff appeared to have a good understanding of people's preferences asking, "Do you want your usual?" and anticipating people's responses.

Menus were on display in the entrance and also in the dining rooms. However these menu sheets covered a four week period and were dated September 2013. We carried out lunchtime observations in both dining rooms on the first day of the inspection.

On the residential unit we discussed the menu and food choices with people who used the service. They told us that they did not know which week it was for the menu or what was available for lunch that day. People told us they were not asked beforehand what they would like to eat but the menu did indicate that a choice of options was available. Everyone we spoke with told us that they liked the food that was provided. When the meal was delivered every person was given the corned beef pie without being offered a choice. When one person asked what was for desert they were told ground rice and they said they did not want that so got up and left the room. Later we asked a member of staff what the alternative was to the rice and she said, "Well they can have ice cream if they wish." We did not see that this choice had been offered. This meant that whilst people told us they liked the food we did not see that people were offered choice to enable their preferences to be followed.

Some of the people who lived at the home had marked problems with their memory and found it difficult to think about recent events or at times, to have a conversation. So that we could understand the experiences they had of care and support, we carried out a structured observation during our inspection called a Short Observational Framework for Inspection (SOFI). This involved spending a substantial part of the visit observing groups of people to see how they occupied their time; appeared to feel; and how staff engaged with them. On day one of the inspection we carried out the SOFI over the lunchtime experience on the dementia care unit. The observations lasted 40 minutes and captured the experiences of five people who used the service. We saw that no napkins or condiments were available to people who were eating their lunch. We observed one person wiping their mouth on the table cloth as a result of this. This did not promote this persons dignity. Meals were placed in front of people without any level of interaction and choice was only offered as a reaction to people not eating the food they were given. Throughout the whole of the observation the atmosphere in the dining room was chaotic. Only two members of staff were present, three people required 1:1 assistance with feeding. Four people wandered around the dining room picking up other people's cutlery and one person drank juice from a large jug as they had not been provided with a drink. The lack of staff available meant that the mealtime was not an enjoyable experience for people, those who required 1:1 assistance did not receive it, with one member of staff assisting two, then three people all at the same time. At the same time these two members of staff were also responsible for serving food to other people who ate independently. This did not encourage or incorporate the principles of person centred care.

We spoke with the registered manager and the regional manager about our SOFI findings and they expressed their surprise as there were five staff members allocated to the unit over lunchtime. They explained that this was to ensure that people who required 1:1 assistance in their bedrooms received it. We spoke about the possibility of staggering the lunchtime experience to ensure those people who required 1:1 assistance received their support undisturbed. The registered manager told us she liked this idea and was keen to implement it.

On the second day of the inspection we carried out observations over the lunch time on the dementia care unit. Staff were more visible and there was a nice relaxed

atmosphere. Staff thanked us for our feedback on day one and said that staggered sittings at lunchtime had helped to ensure that those people requiring support received much more focused support as it had been delivered 1:1. They told us people had eaten more of their meal and they had been able to assist at the individuals' pace. Condiments and napkins were also available to those people enjoying their lunch. This meant that people were better supported to have sufficient to eat, drink and maintain a balanced diet.

We spoke with one of the cook's about their role in ensuring people were encouraged to maintain a healthy and balanced diet. They spoke with us about nutritional values of people who lived at the home. They were knowledgeable about people's dietary requirements and were able to identify those people who lived with illnesses that affected their diet, such as diabetes. We saw that the kitchen staff explored people's preferences, likes and dislikes regarding foods and that this information was accessible to kitchen staff. They also spoke confidently about the use of fortified diets for people whose weight was in decline, for example they told us how they made and offered build up drinks, including fortified milkshakes, and snacks each day. They had recently attended refresher training in relation to nutrition and relevant food hygiene and safety training. This meant that staff were appropriately trained and equipped with an appropriate level of knowledge to ensure that people who lived at the service were encouraged to maintain a healthy, balanced diet.

We saw clear evidence in care records relating to weight monitoring. Where people demonstrated unstable weights, we saw weekly monitoring was initiated. These weekly weights were monitored by care staff and audited on a monthly basis by the registered manager who also shared the analysis with the regional management team. This meant that where concerns about weight stability were identified there was effective monitoring in place.

Good

Is the service caring?

Our findings

People we spoke with told us that they liked living at the home and that staff were caring and understanding. People told us, “They support me a lot but they still allow me to maintain my independence which I like” and another person said, “They are lovely, there is no one to dislike they are all lovely”.

We observed interactions between staff and people who used the service, across the whole home. We saw that staff treated people with kindness and compassion. We saw one person become quite distressed and staff spent some one to one time with this person, calming them down and making them feel relaxed. The emotions of distress were soon taken over with smiles and laughter from the person.

We saw that staff carried out a lot of proactive support and care. For example, approaching people and asking if they required any assistance rather than waiting to be asked. This meant that staff pre-empted the support needs of people who used the service and made themselves available to offer that support as and when it was required. These proactive approaches to support included various aspects of care, such as helping someone to change their clothes after breakfast, or helping someone to use the facilities. At each occasion we saw these interactions to be carried out discreetly and with respect. This meant that people who used the service experienced care and support in a manner that upheld their dignity and privacy.

We observed that staff were respectful of the wishes of people who used the service before engaging people in any care or support. We saw that staff explained what would happen and asked the person if that would be okay. All of these interactions demonstrated kindness and compassion. We saw that one person was visited by an external healthcare professional and that when this visitor approached and spoke with the person they became quite distressed. Staff immediately intervened and explained who the visitor was and what the purpose of the visit was. The familiarity of the staff appeared to calm the person down and they appeared visibly more relaxed when they were aware that staff were present. They asked if the person was happy to go along to their bedroom to have a chat with the visitor and when the person gave consent they proceeded to offer assistance. This meant that people were actively encouraged to express their views and be involved in discussions and decisions about their care.

From the discussions we had with staff it became very clear that the service had a stable staff team that had worked within the service for a number of years. The staff we spoke with described how they felt this contributed to the caring nature of the service saying, “We are all familiar with one other, we have a good understanding of how people want to be cared for and do our very best to make sure that is what they get from us.”

Staff were able to describe to us the transition of people who lived in the home, were aware of people’s backgrounds, their family dynamics and what was important to them at this stage of their lives. As we reviewed care records we found that the information staff had provided to us about individuals was accurate and represented the views and wishes that had been expressed by people who used the service. This demonstrated to us that staff had taken the time to get to understand the people they provided with care and support to ensure they could build caring and positive relationships.

Good

Is the service responsive?

Our findings

We looked at care records of four people who used the service. These records showed that people's needs were assessed and care and support was planned and delivered in line with their individual care plans. Individual choices and decisions were documented in the care plans and they were reviewed monthly as a minimum and as and when appropriate if people's health needs changed. These records demonstrated that changes in people's needs were identified and as appropriate referrals were made to other health professionals to help ensure that people's needs were met in a safe and effective way. This meant that the assessment of people's needs, including the delivery plans remained accurate and responsive to the needs of the individuals.

In one individual's care records we saw that staff had identified, through the monthly evaluation process that they had begun to display a reluctance to have support to maintain their personal hygiene. Although this had been picked up by staff in evaluation we did not see that this information had been used to reconsider the level and type of intervention that was required when delivering this aspect of care. In our discussions with staff they demonstrated that they were aware of this change in behaviours and spoke about the use of encouragement and changes to routines to ensure that personal hygiene needs were met. We discussed with the registered manager the importance of ensuring that when appropriate any issues identified within evaluations were used to refocus the delivery of care.

Care plans we reviewed were person centred. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. The files contained information relating the current health of the individuals but also included previous histories (both social and health). This meant that staff could respond appropriately to any reoccurrence of these matters.

The service had a complaints procedure available within the home. This provided a statement of assurance to complainants that any complaint received would be fully investigated and responded to. This procedure was made available to people who used the service within their 'welcome packs' and was also on display throughout the premises. The procedure contained details of who would be responsible for addressing and investigating the complaint, the timescales that could be attributed to investigation and details of who the complainant could approach if they were unhappy with the outcome. This procedure was supplemented by a formal complaints investigation process. This was for the use of staff and offered guidance in how to initially handle and report any complaints that may have been raised to them.

We saw that the service had received one complaint in the past 12 months. This complaint had been investigated, invitations extended to appropriate third parties to engage in the investigation process and the outcome was fedback to the complainant and senior management in line with the complaints procedure. This meant that the service had effective procedures in place to allow for people to raise complaints and ensure appropriate investigation.

People we spoke with, who used the service, told us that they were aware of how they could complain, but that they had not felt the need to. They told us that staff were responsive to any issues they might raise. One person said, "Staff listen to what you say and things are put right."

When we spoke with people about raising informal concerns they told us that they would approach staff or the registered manager. They said they felt that everyone within the home was very approachable and would feel confident to do that.

Staff we spoke with were able to clearly describe the steps that they would take if they were approached with a complaint, concern or comment. Their responses demonstrated that they had a good understanding of the homes procedures around these areas.

During our inspection the activities organiser was not at work. On the ground floor unit we observed that a member of staff asking a group of eight residents what they would like to do. Comments she received included "Are we going out again", "I would like to read the papers if they are here", and what ideas do you have". They ended up discussing headlines in the papers, having a short quiz and then discussing the different work or things people had done in their lives.

On the first floor unit we found that activities were somewhat limited in the morning. People were sat in the communal lounge but there was no stimulation or meaningful activity on offer. On the afternoon we observed a 'sing-a-long' activity which involved a visitor to the service

Good

Is the service responsive?

singing songs from various eras to people who used the service. We saw that the activity limited engagement from people and that as the activity progressed some people became distracted and began to wander from the lounge.

Guidance issued by the National Institute of Clinical Excellence (NICE) under quality standard 30 states that, 'It is important that people with dementia can take part in leisure activities during their day that are meaningful to them. People have different interests and preferences about how they wish to spend their time. People with dementia are no exception but increasingly need the support of others to participate. Understanding this and how to enable people with dementia to take part in leisure activities can help maintain and improve quality of life' (quality statement 4).

On the second day of the inspection visit a fitness instructor visited the home to carry out 'armchair exercises to music'. People from both units engaged in this activity together and the activity itself produced a very vibrant and cheerful atmosphere.

Requires improvement

Is the service well-led?

Our findings

The home had a registered manager, who was available throughout the course of our two day inspection visit. From our observations we saw that the registered manager was very visible walking around the home. People who used the service told us that they were aware of who she was and what her role was within the home.

In discussions with the staff we were told that the registered manager was very approachable. Staff told us, "It is a really supportive group of staff we have here, we all help each other" and "She (the registered manager) is really approachable, if we raise any concerns with her she addresses them." One member of staff gave us an example of the registered manager acting on comments about equipment and availability within the home. They told us that she got straight on to it and had a delivery arranged within a couple of weeks.

People we spoke with confirmed that there were opportunities for them to attend meetings, 'residents and relatives meetings' but told us that they had never felt the need to raise any concerns at these meetings as the home was so good.

We spoke with staff about the management structure within the home. They described the structure to us and informed us of regional management changes that were about to occur. This meant that staff were aware of the management structure of the service and those managers they could approach outside of the home if they felt they could not approach the registered manager for any reason.

People who used the service told us that they were not aware of the management structure of the provider organisation. Whilst we were talking to one gentleman about his experiences of the home, the regional manager entered the lounge area. The gentleman asked us to explain who this person was and why they were in the home as they had not spoken with her before. This meant that people who used the service were not introduced to visiting managers within their home.

Ahead of our unannounced inspection we spoke with external professionals and third parties to gather intelligence on the home. People we spoke with spoke positively about the home, the registered manager and raised no concerns. We saw evidence that the local authority had recently completed a visit to the home and conducted an inspection against their own requirements. The local authority had rated the home as 'good' against their own requirements.

The home carried out a wide range of audits as part of its quality programme. The regional manager carried out frequent visits as part of a quality monitoring process and performed quality audits in respect of the following areas; care plans, finances, health and safety, quality, human resources, occupancy and interviews. We looked at audits completed in the six months predating the inspection and saw that each audit was similar in nature with repeat actions being identified at each visit. No action plans had been developed following the audits, to demonstrate how and when the identified areas for improvement would be tackled. Additionally the audits completed had not picked up on some of the areas we identified as issues, for example, inappropriate application of the principals of the Mental Capacity Act 2005.

We spoke with the registered manager about the results of the audits completed and how these were used to improve the service. They told us that they did not receive feedback on those audits and as such month on month were not provided with the opportunity to develop action plans for improvement. This meant that whilst the home had a process in place for monitoring the quality of the service we were unable to assess its effectiveness as no evidence of improvements against the findings was available.

This was a breach of Regulation 10 (Assessing and Monitoring the Quality of Service Provision), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 (2) (e) of the Health and Social Care Act 2008 (regulated Activities) Regulation 2014.

There was evidence of internally controlled audits being completed by the registered manager and senior staff. This included areas such as medication audits, maintenance audits and monthly weights. We saw that where issues were identified the manager instructed action plans and we saw evidence of these issues being taken forward for improvement.

The service was registered to carry on a number of regulated activities including, 'diagnostic and screening procedures' and 'treatment of disease, disorder or injury'. During our inspection we found that the home was not

Requires improvement

Is the service well-led?

providing nursing care to people who lived at the service. The registered manager confirmed that the service had not provided nursing care for a number of years. We discussed with the registered manager the importance of ensuring that the service held accurate registration in relation to regulated activities and advised them of the need to apply to deregister the regulated activities that they were no longer carrying on.

During 2014, the registered manager informed CQC of only four notifiable incidents that the service was required to tell us about. We spoke with the registered manager about the importance of completing and submitting timely notifications and gave them advice and guidance on what are 'notifiable incidents'.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 How the regulation was not being met: The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to— Regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations 17 (2) (e)