T.L. Care Limited

Mandale Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 24 October and 1 November 2016. Both days of inspection were unannounced which meant the registered provider and staff did not know that we would be attending.

We previously inspected the service on 13 and 14 November 2014 and found that the service was not meeting all of the regulations which we inspected. We found the service was not meeting the regulations for consent to care and treatment and good governance. This was because the service did not have suitable arrangements in place for obtaining consent. The service had not been following the principals of the Mental Capacity Act 2005 and this had not been picked up by the quality assurance measures in place at the time. There were also gaps in the quality assurance systems in place at the service. We noted that audits had regularly highlighted the same areas for improvement and actions plans had not been put in place following these audits. The registered manager was not given feedback following these audits which meant they had been unable to make the changes needed.

After the inspection on 13 and 14 November 2014, the registered provider supplied an action plan to show us the action they planned to take to improve the quality of the service.

Mandale care home is registered to provide accommodation for people who require personal care, treatment of disease, disorder and injury and diagnostics and screening for up to 57 older people including people living with a Dementia. At the time of inspection there were 46 people using the service who were supported by 39 staff, of which 28 were care staff. The service was located in a residential area within its own grounds and had on-site parking. The service was located close to local amenities and a short distance from the town centre.

The registered manager had been registered with the Commission since 13 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 this inspection, we could see that the service had listened to the feedback provided to them during the last inspection and had made improvements to the quality of the service.

Staff showed they understood the procedures which they needed to follow if they suspected someone was a risk of abuse. Staff were able to discuss the types of abuse which people could be at risk from and how they could help to minimise these risks. All staff spoken with told us they would not hesitate to whistle blow [tell someone such as the registered manager] if they needed to.

Risk assessments were in place regarding people's specific needs and for the day to day running of the service. These were fully completed and had been regularly reviewed. Staff understood the importance of

these to keep themselves and people using the service safe.

Health and safety certificates were up to date and showed measures were in place to ensure the safety of people and staff.

All staff had a Disclosure and Barring Services check in place. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. People and staff told us there were enough staff on duty throughout the day and night to care for them safely. Two relatives thought staffing levels could be increased. We could see staffing levels were regularly monitored.

People received their prescribed medicines when they needed them. From our observations, we could see that people were supported to take them and people were given the time they needed with their medicines.

Staff told us they were supported during their induction period and records confirmed this. We saw staff shadowed more experienced staff whilst they became familiar with people who used the service and the requirements of their role.

All staff were supported to carry out their roles effectively. Staff received regular supervision, appraisal and training. These also included observations of practice.

Staff had increased their knowledge and understanding of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS). Most staff were confident when we spoke with them and felt able to seek further support from the registered manager if they needed to. We noted that not all MCA were decision specific. The operations manager told us they were already aware of this and support was in place to address this and to support staff to increase their knowledge and understanding of MCA.

Staff understood the action they needed to follow to ensure people received adequate nutrition and hydration. Risk assessments and care plans were completed and updated when people became at risk of malnutrition or dehydration and worked alongside health professionalsHowever food and fluid balance records were not up to date. We informed the operations manager and registered manager about this and were assured that action would be taken to address this. .

People told us they had access to health professionals when they needed them. We found evidence of this during inspection from our discussions with people and staff, from our observation of visiting professionals and from the care records.

People and their relatives spoke positively about the care and support they received from staff and told us they enjoyed living at the service. People told us they felt well cared for.

When we spoke with people they were not sure if they were involved with developing and reviewing their own care. We noted that people had not routinely signed their care plans to show they consented to the information in them. People told us that staff always sought their consent before any care and supported was delivered and that they were happy with the care provided to them.

People told us their privacy and dignity was maintained at all times. We observed staff knocking on people's doors and waiting to be invited in. People were also given the time and support needed at mealtimes and when medicines were dispensed. All of which was carried out in a dignified manner.

People had care plans in place which reflected their health and well-being needs and had been regularly

reviewed. We identified some gaps in these records.

We heard mixed reviews about the quality of activities provided at the service. The operations manager and registered manager told us they were both aware of this and plans were already in place to address this.

People and their relatives told us they knew how to make a complaint and felt confident that action would be taken. We could see a small number of complaints had been made and records detailed the action taken to resolve the complaint and the outcome of the complaint.

All staff told us they enjoyed working at the service and felt supported by the registered manager. People and their relatives spoke highly of the registered manager too. During inspection we saw staff worked as a team and regularly communicated with one another.

The service had good links with the local community and people attended events within the community. The local community were also invited into the service for events; these included open days, fundraising activities and visits from local schools.

The service regularly reviewed all accidents and incidents. This meant the service could identify any patterns and trends and take the action needed to minimise the risk of reoccurrence and harm to people.

The registered provider regularly visited the service and carried out quality assurance monitoring. The registered manager also completed a range of audits and developed action plans were any improvements where needed. These were reviewed by the registered provider during their visits.

Staff and people told us they were kept up to date with any changes or events occurring at the service and minutes were available if they had not been able to attend any meetings. We could also see that people had access to regular newsletters and had been invited to participate in the latest survey.

We found staff understood the requirements of their role and worked under the guidance of the registered manager to ensure people received safe care and support. We observed the staff team worked well together and communicated well.

Notifications had been submitted to the Commission when required to do so.

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.

Staff demonstrated a good level of understanding of the different types of abuse people using the service could be at risk from and the procedure they needed to follow if they suspected abuse could be taking place.

Risk assessments for people and for the day to day running of the service were in place and had been regularly reviewed.

There were mixed reviews from relatives about staffing levels, however we found sufficient staff on duty at all times of the day and night to provide safe care and support to people.

Is the service effective?

Requires Improvement

The service was effective.

Staff were supported to carry out their roles effectively. Staff had received regular training, supervision and appraisals.

The service had made improvements to the procedures in place for obtaining consent . We noted that some Mental Capacity Act Assessments (MCA) were not always decision specific, however training was in place to address this.

Staff worked closely with health professionals when people became at risk of malnutrition or dehydration.

Is the service caring?

Good

The service was caring.

People spoke positively about staff. People told us they felt cared for and enjoyed living at the service.

People told us that staff knew them well and respected their privacy and dignity whenever care and support was carried out.

People didn't always know if they were involved in developing and reviewing care plans. However people told us that staff

always sought their permission before any care and support was given. People told us they were happy with the care provided to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We identified gaps in people's monitoring records because staff had not completed them regularly.

Care plans contained information about how to support people and had been regularly reviewed.

People and their relatives gave mixed reviews about the quality of activities in place. However we could see improvements were planned.

People knew how to make a complaint if they needed to and told us they felt confident that the registered manager would take their concerns seriously.

Is the service well-led?

Good

The service was well-led.

Staff told us they enjoyed working at the service and felt supported by the registered manager. People and their relatives spoke highly about the registered manager.

Quality assurance procedures were in place and were regularly carried out. They had identified gaps in the Mental Capacity Act documentation but not in care records; however we were assured that these would be actioned following our inspection.

All accident and incidents records had been regularly reviewed and the Commission had been notified of these when needed.

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.

One adult social care inspector and two experts by experience carried out an unannounced inspection on 24 October and 1 November 2016. This meant the registered provider and staff did not know we would be attending on either days of our inspection. The two experts by experience had experience of supporting older people, including people with Dementia.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from 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 office from the local authority commissioning team about the service and they told us they did not have any concerns about this service.

The registered provided completed a provider information return (PIR) when we asked them to. 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.

During this inspection, we spoke with 13 people who used the service and three relatives. We also spoke with the operations manager, registered manager, three senior care staff, an activities coordinator and nine care staff over the two days of inspection. We also carried out SOFI observations. SOFI is specific short observational framework for inspection, specifically for people living with a Dementia

We reviewed three people's care records and the supplementary records of a further nine people. These included medicine administration records, topical cream records, food and fluid balance records and daily records. We reviewed four staff recruitment records and four staff induction records; we looked at the supervision and training summary records for all staff and four supervision and appraisal records in detail. We also reviewed records relating to the day to day running of the service which included meeting minutes,

quality assurance records and the registered providers' policies.

Good

Is the service safe?

Our findings

People told us they felt safe living at the service and staff told us they would not hesitate to take action if they felt this was not the case. One person told us, "I don't want to go home. It's nice here." Another person told us, "This home is brilliant. I would not want to live anywhere else; there are always people around to help you."

We spoke with staff about safeguarding; they demonstrated a good understanding of the procedures which they needed to follow if they suspected people were at risk of abuse. Staff provided good examples of the types of abuse which they may see in a care setting and the signs and symptoms which people could display. All staff spoken with during inspection told us they would raise any concerns with the registered manager and were confident that action would be taken. Prior to inspection we spoke with the local authority and they told us they did not have any safeguarding concerns about the service.

From speaking to the registered manager and staff, they told us they had not needed to raise any safeguarding alerts. The registered manager told us that they regularly monitored people's health and well-being and if people experienced any deterioration then action was taken to update care plans and any referrals to health and social care professionals were carried out which included safeguarding alerts.

A small number of accidents and incidents had occurred at the service, all of which had included people experiencing falls. Falls for each of these people had been monitored, referrals to health professionals made where needed and appropriate action taken to reduce the number of falls people had experienced. This had included updates to care plans and increased observations by staff.

Staff acted quickly when people were at risk of potential harm. For example, whilst speaking with the registered manager, we saw one person in the corridor without shoes or slippers on. When asked, the person told the registered manager that their slippers were too big for them. The registered manager took the person back to their room to seek appropriate footwear. This meant action was taken to prevent the person from potentially falling. We also observed another person sat in their chair leaning over, whilst attempting to put their slippers on. A staff member noticed this and quickly assisted this person reducing the risk of falling from the chair. This action was carried out in a caring and dignified manner.

Risk assessments were in place for people who needed them; these included assessments in relation to weight loss, pressure sores, falls, manual handling and bedrails. Staff followed the guidance in these risk assessments; during our observations, we saw staff using the correct moving and handling equipment to assist people into wheelchairs and two members of staff were always involved. We could see risk assessments had been regularly reviewed. We noted a small number of gaps in risk assessments, however these had been identified by the registered manager and action taken to address this.

Regular health and safety checks at the service had been carried out. These included call bells, fire exits, wheelchairs and emergency lighting and doors. Checks of call bells showed they were in working order.

Staff had participated in regular fire drills. This meant they were competent to take appropriate action to evacuate people during an emergency situation. Each person who used the service had a personal emergency evacuation plan (PEEP) in place. This information provides staff and emergency services with information about how they can ensure people's safe evacuation from the premises in the event of an emergency. We could see these records detailed the assistance needed and any equipment such as wheelchairs. Each had been regularly reviewed.

Regular checks of water temperatures had been carried out. These showed temperatures were recorded at safe levels; where they were recorded above 43 degrees Celsius, action had been taken to reduce the temperature.

Robust recruitment procedures had been carried out. Records in place showed that each member of staff had two checked references and a Disclosure and Barring Services (DBS) check. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups.

A dependency tool was used to determine whether there were sufficient staff on duty. The registered manager told us that staffing levels were constantly monitored and reviewed during visits from the operations manager. Staff told us there was generally enough staff on duty, but they were always busy. One relative told us, "Staff numbers are OK, but they are very busy." Another relative told us, "Extra staff are needed. It's too busy in here." We passed these comments onto the registered manager. We saw that there were sufficient staff on duty throughout both days of our inspection

We checked people's prescribed medicines to determine whether safe and robust procedures were in place. We found that people received their prescribed medicines when they needed them and any assistance needed to take medicines was given.

People's medicine administration records (MARs) contained a photograph of the person, any allergies and a record of their medicines. We found that MARs were updated when people's medicines were stopped or changed.

Staff checked all medicines when they arrived at the service and checked these against MARs. This helped to ensure people received the correct medicines in the quantities needed.

Some people were prescribed topical creams. We found body maps and topical administration cream records were in place. This meant staff had the information needed about when and where to apply these creams. Records showed people received these as prescribed.

The date of opening had not been recorded on all eye drops which had a limited shelf life. One person's eye drops were still in use despite being opened over four weeks. These types of medicines have a shelf life of four weeks. This is significant because some medicines are less effective if used beyond the timescale indicated. We fed this back to staff and they took immediate action to address this.

Some people received medicines on an, 'As and when needed,' (PRN) basis. Records were in place to show when these medicines had been given. However PRN protocols were always not individual to people. This meant staff did not always know when and why people might need these medicines.

Some people were prescribed controlled drugs. These are drugs which are liable to misuse. We saw that good procedures were in place for the storage and dispensing of these drugs and always involved two staff members.

Medicine audits had been carried out each month and included a sample of several people using the service. The audits included a review of medicine administration records, controlled drugs and checks of medicines. Nurses from the local GP surgeries worked closely with staff to monitor people's prescribed medicines. They also reviewed people's 'As and when' required medicines and carried out medicines audits. This meant the service had procedures in place to monitor the quality of medicines at the service.

Requires Improvement

Is the service effective?

Our findings

At the last inspection, we found the service was not meeting the requirements for Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service had not always carried out Mental Capacity Act (MCA) assessments when they suspected people might not have the capacity to make their own decisions. Where MCA assessments had been carried out, they were not specific to people's individual requirements. Statements within MCA assessment records had included, "Due to dementia, [Person using the service] 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. We also found incomplete MCA records, which meant we could not determine what decisions the assessment related to.

At this inspection, we could see the service had made improvements in this area. MCA assessments were in place for people. We found that many of these MCA assessments were decision specific, although there were still some in place which were not decision specific. Staff training in MCA and DoLS had taken place and staff felt more confident. The registered manager and operations manager were both aware that some staff displayed limited knowledge. The operations manager told us that all staff continued to be supported in this area and stated, "This is a process of change and we continue to work with staff."

There was evidence in people's care records to show that best interest decision making had been carried out for people; these included decisions in relation to personal care, medicines and lap belts for wheelchairs. However, we looked in one person's records and noted that the person's relative had stated this person must only have specific fluids and desserts; the records stated that it was in the person's best interests because blood sugar were erratic. There was no evidence of any best interest's decision and the relative did not have lasting power of attorney. A care coordinator told us, "In Mental Capacity Act (MCA) training, we get staff to understand that people have a choice. All staff received a breakdown of MCA to further increase their knowledge."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the time of our inspection, there were 22 people who had a DoLS authorisation in place; we could see that people had these in place to maintain their safety or to provide support with personal care, eating and drinking and medicines management. The service had a tracker in place which showed when each person's DOL'S authorisation had been granted and when it was due to expire. This prompted the service to make

sure that a review of these deprivations took place prior to the expiry of the restriction.

Some people had 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) certificates. All staff spoken with during inspection understood the requirements of these certificates and checked certificates were in date during reviews of care. One person had a DNAR in place which stated, "Decision made following best interest's with 'Person who has parental responsibility for the child/young person' which is incorrect because the form related to an adult. From speaking with staff, we could see this DNAR had been carried out in hospital, however staff had failed to notice the discrepancies on this certificate. The registered manager told us they would take immediate action to address this.

All new staff participated in an induction programme which involved training, shadowing more experienced members of staff and becoming familiar with the policies and procedures of the service. Induction included completion of the care certificate. This is a nationally recognised set of standards which staff are expected to follow at work. A senior carer told us that all staff were subject to competency checks as part of the care certificate. Regular reviews took place to monitor staff's progress during their induction and to identify any training and support needs.

Records were in place to show that all staff received six supervision sessions and an annual appraisal each year. Dates were planned for staff supervision sessions. Supervision and appraisals are formal methods of support between staff and their supervisor to make sure any needs are identified. Staff told us they felt supported to carry out their role.

Staff told us they received regular training and felt able to meet the needs of people using the service. Staff also told us they felt part of the team and felt supported by the registered manager. We found all staff received mandatory training. This is training which the registered provider feels is necessary for staff to carry out their role effectively. Mandatory training included moving and handling, safeguarding, health and safety, Dementia, fire safety, the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards, pressure area care and nutrition. We also found that staff responsible for dispensing medicines had received up to date training. Not all training was up to date, however planned dates were in place for some training outstanding. The registered manager had an action plan in place to ensure other areas of outstanding training which included managing challenging behaviours and equality and diversity were completed.

We asked people about the food provided to them. One person told us, "The food is very good but they give you too much and it puts you off eating." Another person told us, "It's very ordinary food." Another person told us, "The food is good especially the puddings." One relative told us, "[Person using the service] enjoys the food; they are maintaining their weight."

Everyone spoken with during inspection told us there was no choice of main meal. During our observation of mealtimes, we did not see people being offered a choice. The registered manager told us that alternative choices were available. Staff asked people for their choices on a morning rather than at meal times.

We saw that one person did not want the main meal and dessert offered to them. Staff asked this person if they would like sandwiches instead. When the person declined these, the staff member offered the person biscuits and the person had these for lunch. When we spoke with staff, they told us they could ask for sandwiches, omelettes or jacket potatoes as alternatives, however we did not observe these other options being offered to this person.

Written menus' were on display in communal areas, however we noted these were in small font and no pictorial menus were on display. Menus were not accessible to people and people we spoke with were not

aware of the menu for the day.

We observed staff encouraged people to eat their meals and attempted to distract people when they got up to leave the table on the Dementia unit, in order to re-focus their attention back to their food. This resulted in people continuing to eat their meals. People were offered a choice of drinks at mealtimes and staff encouraged people with their hydration. We observed one staff member assisting one person to eat, however they regularly left this person to carry out other duties which serving other people with their meals and drinks. This meant this person was not given the time or support they needed to eat their meal. We observed one person trying to eat ice-cream without any cutlery. We had to intervene to give this person a spoon to enable them to eat their dessert.

Food and fluid records were in place for people who needed them. This enabled staff to monitor the nutrition and hydration people were receiving. We noted that on the day of inspection, people's fluid balance records had not been completed until the afternoon; this meant that we could not be sure of the accuracy of volumes of fluids which had been recorded for the morning.

We found that people were generally receiving regular fluids, however there were no target amounts of fluids recorded for people and where people had received less than 900 millilitres of fluid each day, there was no evidence of action taken to address this. We also identified that no action was recorded when people missed meals and the amount of food eaten was no documented. This meant it was difficult to ascertain if people were receiving adequate nutrition. From speaking with staff, we could see that staff did prompt people with snacks and evidence showed referrals were made to dieticians when people became at risk of malnutrition and dehydration.

During our observations, we saw that people were given drinks which were placed on the floor next to where they were sitting. We noted there were not enough small tables to accommodate people who needed drinks at the same level at which they were sitting. We saw that some people could not reach the drinks on the floor and some people living with a Dementia did not see the drinks.

Our findings suggest that people living with a Dementia are not always receiving appropriate support with their nutrition and hydration which includes choices of nutrition and hydration.

People had regular access to health and social care professionals. During inspection we observed GPs and district nurses visiting people at the service. People told us they got the help they needed when they experienced a deterioration in their health and well-being. Relatives told us people were supported to attend healthcare appointments. One told us [Person using the service] was waiting for a hearing test; staff had taken action to make a referral and the relative was happy with action the service had taken.

Good

Is the service caring?

Our findings

People spoke positively about the care which they received from staff. People told us staff were, "Kind," "Good," and "Excellent." One person told us, "The staff are excellent, there is always someone around and you are always greeted with a smile on their face. Nothing is too much trouble." Another person staying for respite care told us, "I have had a good stay and the carers were very kind." One relative told us, "[Person using the service] received good care and was never left on their own."

Relatives spoke positively about the service. One relative told us, "I'd like to say how good staff are. Since [Person using the service] came here, within a week we saw massive improvements in them. Staff have been lovely with [Person using the service]; they look after people as if they were their own. [Registered manager] takes action when they need to."

One staff member told us, "I love it. The staff are nice and helpful. The residents are lovely." The registered manager told us, "The service Mandale [Care home] provides is provided by dedicated staff who are intent on ensuring the people who live here are happy and content. Staff work hard and make sure all the needs of residents are met. But one aspect of the care they provide which gives me the most satisfaction is when I observe a carer sitting with a resident either talking to them or just sitting together with a cup of tea."

We carried out observations during our inspection which included SOFI observations. SOFI is specific short observational framework for inspection, specifically for people living with a Dementia. We observed little meaningful interaction between people and staff at times. For example, a person using the service spoke to a staff member when they walked into the lounge however the staff member did not respond to them. On another occasion, a staff member brought this person a cup of tea and told the person what this drink was but said nothing else to them. We also observed staff walking through communal areas, such as the lounge and not speaking with people.

We asked people if they were involved in planning and reviewing their own care. Most people we spoke with were unsure if they were involved in making decisions about their own care. We did observe staff asking people's permission before any care and support was carried out. People's care plans contained information about how to respond to people's individual needs and preferences. For example, care plans for one person told staff about the risk of choking when coughing during meals; how often the person needed to visit their hairdresser, preferences for activities and speaking face to face with the person using a loud tone of voice.

Staff were aware that some people may need support with their decision making and told us they would try to involve people's families. Where this was not possible, people would be signposted to the local advocacy service which is a means of accessing independent support to assist with decision making.

People told us their privacy and dignity was respected and maintained. Staff told us how they helped to do this, which included giving people the time they needed whenever care and support was carried out, as well as closing curtains and doors and waiting for people to give their consent.

During our observations, we saw that one person had fiddled with the tap on their urine bag which meant it had started to leak in the communal area. We alerted staff to this and they dealt with the situation quickly, maintaining the dignity of this person. We also noted that the staff member made sure that other people in the communal area were protected from the risks of infection.

Relatives told us they could visit the service whenever they wanted to and felt welcome by staff. Relatives told us they could choose to sit with people in communal areas or in their bedrooms if they wished. We observed relatives in people's rooms; people told us they were happy with this. One relative told us, "I can come here anytime. I have done early morning and late evening."

From speaking with staff we could see that people were receiving care and support which reflected their diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there, which included age, disability, gender, marital status, race, religion and sexual orientation. This information was appropriately documented in people's care plans. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this.

Requires Improvement

Is the service responsive?

Our findings

Care plans were in place for people which detailed the care and support which people needed. They contained detailed information and were individual to people. For example, for one person, a nutritional care plan detailed the importance of portion size and spacing out food otherwise the person could become overwhelmed and reluctant to eat. People's personal preferences were included in their care plans which meant that staff could deliver care and support which reflected people's needs, wishes and preferences.

However, we also noted repetition between care plans for people and questioned whether all of them were needed. For example, for one person, we found care plans for maintaining a safe environment and mobility were similar because each focused on falls.

We noted some gaps in people's care plans. However we were told that improvements were being continually made. In one person's care records, a care plan for 'Mental state' said "Due to the person's mental state, [Person using the service] needs staff to explain things so [Person using the service] understands." The care plan did not state what the 'Mental state' was and what the person's level of understanding was. From speaking with staff we ascertained this person was living with a Dementia, however it was not clear in the care plan and did not provide any information about what the person could understand.

We looked at a diabetic record for one person who needed to have their blood sugar checked three times per day at meal times. Records looked between 6 and 23 October 2016 showed this happened on six occasions. We found that records had not been completed on some days and on less than the three occasions required on the remaining days. Where a blood sugar was recorded as 30.9, the care records did not show the action staff had taken to address this. We spoke to a senior carer and the registered manager and could see that blood sugar had been monitored three times per day and appropriate action taken when blood sugar was outside of normal range. The registered manager told us that action would be taken to ensure these records were kept up to date.

Staff did not follow guidance in the nutritional risk assessment they used [Malnutrition universal screening tool (MUST)]. For example, one person had a MUST score of two which stated that the person must be weighed weekly and care plans update, however we noted that this person was only weighed each month and care plans had not been updated. From speaking with the registered manager we identified this was a training issue and they told us they would take action to address this.

We found that some care records contained gaps in information. Pre-admission assessments were incomplete and not always signed by the staff member completing them. This meant that the service did not have all of the information needed to determine people's suitability for the service and whether the service could provide personalised care and support. Gaps in these pre-admission assessments included medicines, weight loss, mobility equipment, mental capacity and information about communication aids.

We also noted in one person's reviews that they were not wearing their dentures and reading glasses,

however records did not show if staff had taken action to involve a dentist and optician to carry out a health review.

During inspection, we looked at how people spent their time and whether they had enough meaningful activities. People and relatives told us that the quality of activities could be greatly improved at the service. Some people told us they would like to go out into the community more often and wished staff had the time to sit and chat with them.

We saw one activity taking place on both days of our inspection. People told us that activities did sometimes take place. One person told us they had been "Baking and made cornflake chocolate cakes and queen cakes with cream on top." Another person told us, "Staff took me to Redcar and Saltburn." Some people chose to stay in their rooms. Newspapers were available for people that wanted them. Music was being played in several places.

We noted there was a lack of activities records in place and no evidence of feedback from people using the service available during inspection about activities. We also noted that the activities timetable on display during inspection was not up to date. This meant people were not aware of the activities taking place. People and their relatives told us that activities did not always take place. Some relatives we spoke with were concerned that there were not enough meaningful activities for people. During both days our inspection we saw people sitting in silence, or asleep throughout the day. When we discussed activities with the registered manager and operations manager, they told us they were aware of our findings and felt the level of activities would improve because another activities coordinator was returning to work soon following a period of long term leave. The registered manager told us, "As much as the residents have activities provided, I feel, at times we lack in providing that extra motivation. We have just completed a sensory room. This is especially good for people with Dementia."

A small number of complaints had been made; records were in place which showed that appropriate action had been taken to investigate and respond to the complaints. Everyone we spoke with during inspection told us they knew how to make a complaint. No one during the inspection wished to do so. The complaints procedure was on display at the service. One person told us, "If you talk to the manager, they will sort things out."

Good

Is the service well-led?

Our findings

At the last inspection, we found the service was not meeting the requirements for Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not regularly assessed and monitored the quality of the service it provided. Audits been completed, however they had not identified the concerns we had during that inspection, especially in relation to the Mental Capacity Act (MCA). There were no action plans in place for audits and we noted audits had picked up the same concerns without action having been taken. The registered manager had not been given appropriate feedback following these audits.

At this inspection, we could see that the registered provider had taken action to improve quality assurance processes in place at the service. Improvements had been made to the way the service assessed if people had capacity to make their own decisions and procedures were in place when staff suspected people may lack capacity.

We also found that audits were regularly being completed by the registered manager. These included audits in relation to medicines, weight loss, pressure area care, infection prevention and control, mattresses, activities, food safety and, staff sickness and care records. We noted that the registered manager was already aware of people's feedback surrounding meaningful activities at the service; however they were not aware of the gaps in records which we identified. The registered manager and operations manager told us that further changes to quality assurance process would take place.

Results of audits and information relating to accidents, incidents and safeguarding alerts were shared with the registered provider. Where audits had identified areas for improvements, action plans were in place and were discussed each month when the operations manager visited the service. During these visits, the operations manager carried out their own audit of the whole service. The registered manager received feedback about this, an action plan was put in place and this was checked at the next visit.

In addition to audits to monitor the quality of the service, the registered manager told us they carried out observations of staff to monitor their performance and to identify areas of good practice and shortfalls in care. They told us these were carried out every month on both units at the service.

At the time of our inspection, surveys to assess the quality of the service were being collated; we could see that nine surveys had been received. Feedback from these was generally positive. Two relatives felt activities could be improved, however they rated the home as "Excellent," and one stated, "Everything in the care home is very excellent and the staff too."

Regular meetings had been carried out with people, their relatives and staff at the service. This meant people were kept up to date with any changes occurring at the service and upcoming events. We also saw that the registered manager and operations manager attended regular meetings with the registered provider to discuss the quality assurance of the service.

Staff told us they enjoyed working at the service and saw a future with the registered provider. Staff spoke positively about the registered manager. One staff member told us, "You just need to ask [Registered manager] and they will do what they can for you." Another staff member told us, "The staff morale is cheerful and we get what we want, when we need it. The [Registered] manager is approachable."

One relative told us, "[Registered manager] runs a tight ship." Another relative told us, "The [Registered] manager is lovely, and very good. They act straightaway.' The registered manager had been in post since 13 January 2013 and was aware of the requirements of the role of registered manager. They had submitted notifications to the Commission when required to do so. This included safeguarding alerts, the death of a service users and incidents occurring at the service.

The service was located in a residential area and close to local amenities. Staff told us the service had good links with the local community and said people's relatives and friends visited often. School children attended planned visits throughout the year. The registered manager told us, "Mandale [Care home] have links with the local community. The library is often used for us to do cake stalls, which our residents help to bake. All funds raised go into our resident's fund. The local schools visit; some children read to our residents. It is obvious by the smiles on resident's faces, they are enjoying the company of the school children. We also have weekly visits from the local church, which many of our residents receive comfort from."