

Amethyst Arc Ltd

# Mandalay Care Home

## Inspection report

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## Ratings

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

# Summary of findings

## Overall summary

This inspection took place on 18 and 19 June 2018 and was unannounced.

Mandalay is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Mandalay Care Home accommodates up to 46 people in one building including the use of an attached small dementia suite called the Sunflower unit. There were 40 people using the service, 10 people living in the Sunflower unit and 30 people in the main building. People cared for were all older people; some living with dementia and some who could show behaviours which may challenge others. People had a range of care needs, including diabetes. Some people needed support with all personal care and some with eating, drinking and their mobility needs, while other people were more independent.

Bedrooms are situated over three floors and can be accessed by the passenger lift; the premises are suitable for people with physical mobility problems. People had access to assisted bathrooms and a dining room/lounge/conservatory and enclosed rear garden.

The registered manager worked at the service each day and was supported by a deputy manager. A registered manager is a person who has registered with CQC 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 last comprehensive inspection on 4 and 5 April 2017 the overall rating of the service was, 'Requires Improvement'. We found there was one breach of the regulations. This referred to shortfalls in the systems and processes intended to check and improve the quality service provided. That inspection also identified other shortfalls about the management of mattresses and equipment intended to help protect people at risk of skin damage. There was also underdeveloped guidance for staff about how to support some people whose behaviours could challenge.

We asked the provider to complete an improvement plan to show what they would do and by when to improve the key questions of Safe and Well-Led to at least 'Good'.

At this inspection, improvements in monitoring and resolving problems in the running of the service resulted in sufficient progress to meet the previously breached regulation. However, we concluded that more progress was still needed to ensure these processes were fully embedded so that consistency of records and development of the service was maintained. Previous areas identified as requiring improvement, about mattress equipment and guidance for staff, had suitably improved. However, we identified other areas requiring improvement relating to the safe storage of an oxygen cylinder and some medicine records

checks. These were resolved on the day of the inspection.

People were protected from harm by staff who were trained to recognise signs of abuse. Where risks to people were identified, staff acted to minimise them. There were enough staff to meet people's needs and staff were recruited safely. Medicines were stored, given to people as prescribed and disposed of safely by properly trained staff. People were protected from the risk of infection by robust prevention and control measures. Analysis and reflective practice meant lessons were learned when things went wrong.

People's needs were assessed before they moved into the service. These needs were met by staff who had the skills and knowledge to deliver effective support. People were supported to eat and drink enough to have a balanced diet, including those with complex health needs. People were supported to have healthier lives by having timely access to healthcare services. People lived in an environment which was suitable for people living with dementia. People were supported to have maximum choice and control of their lives, staff supported them in the least restrictive way and the policies and systems in the service reflected this practice.

People received a service which was caring, they were treated with dignity and respect. Staff were compassionate and caring, this was commented upon positively by people and their visitors. Staff treated people's private information confidentially. People, where possible, made decisions about how their care was provided and were involved in reviews of their care together with people important to them.

Care was personalised to people's individual needs and preferences. A range of activities were available for people to participate in if they wished and people enjoyed spending time with staff. Staff knew people's interests and needs well. There was a complaints policy available to people. Staff were open to any complaints and understood that responding to people's concerns was a part of good care.

People and staff were positive about the culture of the service, people and relatives felt the staff team were approachable and polite. The staff team worked with other organisations to make sure they followed current good practice. Maintenance records for equipment and the environment were up to date. Policies and procedures had recently been updated and were available for staff to refer to. Staff said they were encouraged to suggest improvements to the service. Relatives told us they could visit at any time and were always made to feel welcome and involved in their relative's care. People were supported at the end of their life to have a dignified and comfortable death.

The provider's vision and values were embedded into the service, staff and culture. Governance systems were largely effective in ensuring shortfalls in service delivery were identified and rectified. The provider had sent CQC notifications in a timely manner. Notifications are changes, events or incidents that the service must inform us about.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was safe and had made the improvement required in this area following the previous inspection.

Risk to people had been assessed. There was clear guidance for staff to follow to reduce the risk, including when behaviours challenged.

Accident and incidents were recorded and action taken to reduce risks of reoccurrence.

Staff had attended safeguarding training and had a clear understanding of abuse, how to protect people and what to do if they had any concerns.

Medicines were managed safely by appropriately trained staff. Systems in place ensured medicines were given as prescribed, stored and disposed of properly.

Good 

### Is the service effective?

The service was effective.

Care was delivered in line with national guidance and care staff had received training and support.

People were supported to eat and drink enough to maintain a balanced diet.

People were assisted to receive coordinated care and to access ongoing healthcare support.

Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance.

Good 

### Is the service caring?

The service was caring.

Staff understood and promoted care practice to support people's privacy, dignity and independence.

Good 

People were supported to express their views and be actively involved in making decisions about their care as far as possible.

People were enabled and supported to maintain relationships with families and friends.

Private information was kept confidential.

### **Is the service responsive?**

**Good** ●

The service was responsive.

Care plans had guidance for staff to follow if a person's health needs change or if they needed end of life care.

People received personalised care and were included in decisions about their care and support.

A complaints policy and procedure was in place and available to people.

Feedback from people was sought and their views were listened to and acted upon.

### **Is the service well-led?**

**Requires Improvement** ●

The service was not consistently well led.

Systems and processes used to assess and monitor the quality of service needed to be strengthened further to ensure progress made was sustained.

Care staff understood their responsibilities so that risks and regulatory requirements were met.

The service continuously learned and improved and staff were given opportunity to progress.

The service worked effectively in partnership with other organisations and agencies.□

# Mandalay Care Home

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 used information the registered persons sent us in the Provider Information Return. This is information we require registered persons to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about. We also invited feedback from the commissioning bodies who contributed to purchasing some of the care provided in the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

We visited the service on 18 and 19 June 2018 and the inspection was unannounced. The inspection team consisted of one inspector.

We met and spoke with 13 people who lived at the service, we observed some people's care, the lunchtime meal, some medicine administration and some activities. We spoke with three people's relatives. We inspected the environment, including the laundry, bathrooms and some people's bedrooms. We spoke with two senior carers, two care assistants and some housekeeping staff as well as the deputy manager, registered manager, service administrator and operations manager.

In addition, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us.

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

We displayed a poster in the communal area of the service inviting feedback from people, relatives and staff. Following this inspection visit, we did not receive any additional feedback.

# Is the service safe?

## Our findings

At our last inspection on 4 and 5 April 2017 we found two concerns and identified them as areas requiring improvement. These were about the introduction of checks needed to ensure pressure reduction mattresses were correctly set to allow them to operate safely and as intended. Additionally, where some people had behaviour that could challenge, some care plans did not give clear guidance for staff follow.

After the inspection the registered persons wrote to tell us that they had made all the improvements that were necessary to put right each of the shortfalls.

At this inspection we found action had been taken to address our concerns. Daily checks and regular audits ensured pressure reduction mattresses were correctly set and we observed this to be the case during the inspection. Care plans contained clear guidance for staff to follow where people had behaviour that could challenge; staff were aware of potential triggers and we saw several instances of staff defusing behaviour that potentially may challenge others.

People who used the service and their relatives told us they felt safe. One person who used the service told us, "Yes, I feel safe here, I'm looked after and cared for". Another person said, "There is nothing that worries me, I think we are all treated well, even the difficult ones". A visitor told us, "I would absolutely recommend the home, I have never felt uneasy about mum staying here".

People told us they received their medicines safely and on time. Medicines were securely stored at appropriate temperatures and administered by senior care staff who had received the necessary training and regular competency checks. We observed some medicine being given to people, staff ensured people received their medicines safely, on time and staff signed that it had been given. Medicine administration records (MAR) included a photograph of the person with a list of any known allergies and showed medicines had been administered as prescribed. Other records confirmed when medicines were received, the amount held in stock and when unused or spoiled medicines were disposed of.

Guidance was clear on how to support people to take their medicines, including 'as required' (PRN) medicines, such as paracetamol and laxatives. There was a clear audit trail that showed what action was taken following any errors, including medicines retraining and fresh competency tests. A policy and process was in place where people received their medicines covertly (disguised in food or drink). Before covert medicines were given, correct process was followed to determine if to do so was in a person's best interest. Documentation also confirmed this method of administration had been approved by the prescribing GP and pharmacist. Care staff were responsible for the application of skin creams and recording if it had been done. Discussion with the registered and operational managers found record keeping for the administration of skin creams had been flagged following recent internal audits as an area for improvement. Although care staff were aware of the requirement to keep these records, measures to ensure this always happened still required further embedding. We also spoke with the registered manager about the safe storage of oxygen cylinders as current arrangements did not meet the requirements of the service's policy. Following discussion with the cylinder supplier, appropriate arrangement was made.



Risk assessments provided guidance about how to support people in a safe manner to reduce any health or social risks, including behaviours that may be challenging for the person or to others. Risk assessments were person specific and based around individual support needs. These gave techniques and strategies about how people should be best supported in a way that was acceptable to them.

Accidents and incidents were recorded and each was reviewed by a member of the management team to look for any trends or patterns. Risk assessments were updated where needed and any serious incidents were escalated to other organisations such as safeguarding teams and CQC. Staff took appropriate action following accidents and incidents to prevent reoccurrence and ensure people's safety. Any subsequent changes or action was shared with all staff, this demonstrated learning from incidents and accidents took place.

Care plans contained risk assessments specific to health needs such as mobility, continence care, catheter care, falls prevention, nutrition, pressure damage and a person's overall dependency. Care plans detailed people's identified risks and included a plan of action and guidance for staff to promote safe care. Advice was sought from district nurses and checks were in place to ensure mattresses operated correctly. People who lived with diabetes had a care plan detailing the symptoms and action to take in the event of hypoglycaemia (low blood sugar) and hyperglycaemia (high blood sugar). As well as setting out their safe blood sugar level range, it also ensures other concerns linked with diabetes were monitored, for example foot and eye care. Staff were aware of the risk assessments and understood them.

Recruitment checks ensured the staff who worked at the service were suitable to work with vulnerable people. These included references from previous employers, identity and work history checks as well as completion of a disclosure and barring service (DBS) check. DBS checks information held police national databases about any convictions, cautions, warnings or reprimands. This helps employers make safer recruitment decisions to help prevent unsuitable people from working with vulnerable groups.

Staff received training in safeguarding adults and records confirmed this. Staff understood their roles and responsibilities in supporting people to keep safe from potential harm or abuse. They were knowledgeable about the different forms of abuse and how to recognise the signs of abuse taking place. Staff told us they would not hesitate to report abuse to the registered manager and were confident they would take appropriate action. The registered manager understood their responsibilities in reporting any concerns about people's safety which included reporting incidents of potential harm or abuse. Policies and procedures were in place for whistleblowing and safeguarding, as well as policies in relation to bullying and harassment. Staff told us they felt protected to whistle blow. A whistle blower is a person who informs, in confidence, on a person or organisation. We discussed with staff how they made sure people were not discriminated against and treated equally and without prejudice. A staff member told us, "We treat everybody equally, but individually and are mindful of people's life choices, everyone is treated with dignity and respect".

Potential emergencies were planned for, there were robust fire procedures which included individual Personal Emergency Evacuation Plans (PEEP). PEEPs identify people's individual independence levels and provide staff with guidance about how to support people to safely evacuate the premises. The provider recorded and evaluated fire drills and all staff received fire training. A business contingency plan set out possible emergencies such as extreme weather, infectious diseases, damage to the premises and loss of utilities and computerised data. The procedures identified ensured people had continuity of service in the event of adverse incidents.

Risks associated with the safety of the environment were identified and managed appropriately. Health and

safety checks were undertaken to ensure safe management of utilities, food hygiene, hazardous substances and legionella. Maintenance and servicing of equipment such as the fire alarm, portable electrical appliance testing (PAT), lift, and boiler were routinely undertaken.

People were cared for in a clean, hygienic environment. The service and its equipment were clean and well maintained. There was an infection control policy and other related policies to guide staff in the prevention of cross infection. People and visitors told us that they felt the service was clean and well maintained. One person said, "It's is very clean, they never stop cleaning". Protective Personal Equipment (PPE) such as aprons and gloves were readily available and used appropriately during our inspection. Toilets and bathrooms were clean and had hand towels and liquid soap for people and staff to use.

## Is the service effective?

### Our findings

People told us they received effective care from a staff team who knew them well. One person told us, "I couldn't have hoped for better, the staff are great, they're on the same page and clued in about how to help me." One visitor commented, "The manager and all of the staff actually are prompt in addressing any questions or issues about dad's condition." Another visitor told us, "The staff are picked very well, I have no concerns."

People's physical, emotional, mental health and their social care needs were assessed when people were considering moving to the service to make sure staff could provide the right support in the way people preferred. The initial assessments were used as a base for developing a care plan which centred on the specific needs of each person and were in line with best practice.

Staff completed an induction when they started working at the service and each part of this was signed off as it was completed. New staff, who had not previously worked in adult social care completed the Care Certificate. This is an identified set of standards that social care workers should keep to in their daily working life. It was put in place to help new care workers develop key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high-quality care. New staff shadowed experienced colleagues to get to know people and their preferred routines. Staff competency in each area of their role was assessed and signed off by their mentor or the registered manager. We observed staff using equipment to move people safely and following guidelines set out in people's care plans.

People were supported by staff who were trained and knowledgeable. They completed training to keep up to date with best practice to make sure they could provide effective care and support. Mandatory training was up to date and additional training for topics specific to the needs of the people living at Mandalay Care Home were provided. These included dementia awareness, positive behavioural support, epilepsy, diabetes and catheter care training. Some staff had also undertaken care of the dying training to support people at the end of their life to have a comfortable, dignified and pain-free death. Staff spoke knowledgeably about people and their health conditions, they said the training they received helped them to understand people and to be able to provide the right support.

People were supported to eat and drink enough to maintain a balanced diet. People were happy with the times they received their meals and they could ask for snacks at any time. People appeared to enjoy their meals; a choice was available at lunch and supper. Picture cards were used to help some people decide what they would like to eat. Most people ate in the dining areas. Meals were served hot and the atmosphere was relaxed, a social occasion and people were given the time and support they needed. Some people ate using adapted cutlery or plate guards to enable them to eat independently. Some people ate in their bedrooms and, if needed, staff supported people to eat and drink. The kitchen team were aware of people's different dietary needs and any dislikes and favourite meals. Staff understood about the different types of diets people may need. During the lunchtime meal, we observed some people had pureed meals, as recommended by health professionals. Where people had been assessed as needing thickened fluids, these were provided. Staff knew which people had these and how they should be prepared.

People were supported to stay as healthy as possible. When there were any concerns about people's health, staff made referrals to health care professionals to seek support and guidance. Staff monitored people's physical and mental health and took prompt action when they noticed any changes by reporting changes to senior staff. People told us staff reacted quickly if they were unwell and this view was shared by relatives we spoke with. People had been referred to occupational therapists, the community mental health team and district nurses. Guidance given by healthcare professionals was followed by staff. People received effective support, in a timely way. For example, if they became anxious or unsettled, staff knew how best to support people, what the possible triggers may be and how to distract, divert and reassure them. There was clear guidance for staff to follow in people's care plans about how to do this. Throughout the inspection people were settled in the company of each other and staff.

People's consent to some aspects of their care and treatment had been formally sought. Verbal consent was sought by staff for day-to-day matters like asking permission to go into people's bedrooms or when giving people medicines. People made day to day decisions, such as when to get up and go to bed and what to wear and were encouraged to be as independent as possible about their support. People had access to private and communal areas including the garden and could choose where they wanted to spend their time.

Some people lacked mental capacity to make some decisions and in these cases, a detailed decision specific mental capacity assessment had been made. These are necessary to comply with the principles of the Mental Capacity Act 2005. 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 much as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their interests and as least restrictive as possible.

Staff spoke with people's relatives, representatives and health professionals when they were unable to make an important decision for themselves. For example, undergoing major dental treatment, to make sure decisions were made in people's best interest.

People can only be deprived of their liberty so that they can 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 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. Applications had been made and renewed in line with guidance. When recommendations or specific conditions were made, these were followed and people's representatives were updated as required.

Mandalay Care Home is a large converted and extended house with a garden. The building had been adapted to meet people's needs including the installation of a lift and specialist bathing equipment. There were areas where people could meet with their relatives privately and where activities could take place. Hand rails helped people to move around the building, large, dementia friendly, pictorial and written signs were used to identify the toilets and other rooms to help people find their way.

## Is the service caring?

### Our findings

Feedback about staff from people and relatives was positive. People told us, "The staff are really so very kind, gentle and caring. It seems to be a part of their culture." A visitor told us "The care is beyond reproach, nothing is too much trouble. The staff are very special." Our own observations showed that staff spoke with people in a gentle and kind manner and supported them appropriately.

People were treated respectfully and with dignity. Staff were responsive to people's needs and requests for assistance. People and their relatives felt staff were sympathetic and genuinely cared about the people they supported. Staff spoke with people in an appropriate way, explaining what they were doing and reassuring people as they supported them. Staff were patient with people giving them time to respond to questions and express themselves. Staff listened to people to find out what they wanted and explained how they were going to meet this.

Staff knew people and their backgrounds well, and could speak with them about their lives, people and events that were important to them. People told us staff supported them in the way they preferred and enabled them to be as independent as possible. People were supported to move around the service as independently as possible. We observed staff supporting people to walk around with mobility aids such as walking frames. Staff were patient with people and allowed them to go at their own pace. Staff spoke with people as they walked and reassured them and reminded them to use their equipment.

People were encouraged to decorate their rooms with personal items such as photos and ornaments that were important to them. Relatives told us they could visit whenever they wanted and were always made to feel welcome; they were greeted by name and offered refreshments. One visitor told us, "The staff are always extremely welcoming. When mum moved in they helped us to decorate the room and put pictures up to make it feel like home."

People and their relatives told us that they were involved in discussing their needs with staff so that their care was tailored to their personal preferences. We observed staff asking people how they felt. When one person said they were in pain, staff offered painkillers and asked if they would like to see a doctor. Relatives told us that they were kept informed when their family member's health had deteriorated or if they had been involved in an incident.

People told us and we observed, staff knocking on people's doors and waiting to be invited in before entering. Staff told us and people confirmed that they maintained people's dignity by closing the curtains and covering them when providing personal care. If people needed urgent or unexpected support in a communal area, screens were put in place to ensure people's privacy. Staff were discreet when supporting people to use the bathroom and we observed staff respond to these needs in a timely way.

Some people were unable to express their views about their care, so staff ensured that decisions were made involving people who were important to them including their family and friends. Some people had nominated a person to represent them, however, some people had not. When this was the case, staff knew

how to refer people to advocacy services when they needed support. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf. Information was provided in a way that was meaningful for people living with dementia to help them make decisions and be involved. For example, some information was available in picture format.

People told us that they could speak with relatives and meet with health and social care professionals in private if this was their wish. Records also showed that care staff had assisted people to keep in touch with their relatives by post and telephone.

Suitable arrangements had been made to ensure that private information was kept confidential. Written records which contained private information were stored securely when not in use. Computer records were password protected so that they could only be accessed by authorised members of staff.

## Is the service responsive?

### Our findings

People received care and support which was individual, responsive to their needs and written with them and those who knew them best. People told us they would speak to staff if they had any worries and that they would help them. They did not have any complaints.

Each person had a care plan which staff referred to so they could provide the right care and support. There was information for staff about people's backgrounds, the things they liked and disliked, how much they could do independently and people who were important in their lives. Care plans were reviewed regularly and updated when there were any changes in people's needs to make sure staff provided the right support. Some care plans had been written in an easy to read way with pictures and others were in the process of being updated to this format.

People's needs were responded to in a timely way. Staff knew people well and could identify small changes in their health or behaviour which may indicate they were feeling unwell. For example, staff had noticed a person's mood being lower than usual following a review of their medicines. They immediately arranged for a further review and the person's medicines were increased. This had a positive impact on the person who had become happier, more settled and less anxious.

People were supported to follow their religious, spiritual and cultural beliefs. People's religious beliefs were discussed and recorded to enable staff to support people. The local church visited the service and people could attend if they wished. Staff were considerate of people's ethnic origins and culture. For example, some staff of the same nationality as one person provided them with snacks native to their country of origin. The person was visibly moved by their thoughtfulness. The registered manager told us kitchen staff would also make meals for people that were traditional in their countries of origin.

Staff were aware and care plans contained information about people's cultural and spiritual needs regarding their end of life care. Some people had said that they didn't want to discuss end of life care at that time. Staff were sensitive when they spoke with people about the subject and, if people didn't want to talk about it, they would ask them another time. The registered manager told us if relatives wanted to stay with their loved ones this would be arranged.

At the time of our inspection no one was receiving end of life care, however, the service had adopted a system of 'Just in Case' medicines to support anticipatory prescribing and access to palliative care medicines for people who were approaching the end of their life. People often experience new or worsening symptoms outside of normal GP practice hours. The development of 'Just in Case' boxes seeks to avoid distress caused by poor access to medication during out of hours periods. This is done in conjunction with a GP by anticipating symptom control needs and having these key medicines available in the service.

Some people had completed an advanced care plan that detailed the care and support they required and whether they wanted to be admitted to hospital or not. Staff, the person's GP and family were aware of the advanced care plans, helping to ensure that people's final wishes were respected. Staff reviewed the care

plans regularly to ensure that this still reflected people's wishes.

The activities coordinator recognised the importance of offering people a wide range of opportunities to pursue their hobbies and interests as well as taking part in a range of social activities. People could attend regular group activities together with one to one support. During our inspection, we observed a number of people enjoying singing along in a group activity led by a visiting musician. In another area people enjoyed arts and crafts, some people sat and read, others watched the televisions and chatted with staff and each other. Where some people preferred to stay in their bedrooms, staff ensured they visited regularly. There was an inclusive atmosphere in the service that promoted people's wellbeing. Other external entertainers called to the service to lead activities such as gentle exercises. The activities coordinator also told us that plans were in place to support people to visit places of interest over the coming months.

Personal milestones were acknowledged, for example, people were helped to celebrate their birthdays in a manner of their choice. This usually involved the chef baking them a special cake. People had also been supported to share in national events, for example Remembrance Sunday and more recently the Royal wedding. People were supported to exercise their community citizenship to put their name on the electoral roll and cast their vote if they so wished.

Care staff understood the importance of promoting equality and diversity. This included arrangements that had been made for people to meet spiritual and cultural needs through religious observance. The registered manager recognised the importance of appropriately supporting any people who had adopted gay, lesbian, bisexual, transgender and intersex life-course identities. This included an awareness at preadmission assessments of how to support people to maintain their life choices.



## Is the service well-led?

### Our findings

At our last inspection on 4 and 5 April 2017 we reported on a breach of regulations because suitable provision had not been made to assess, monitor and improve the quality and safety of the service. Specifically, guidance about how to support people with some behaviours was not always completed and, although identified as an urgent requirement, a system had not been introduced to make sure pressure reduction equipment was correctly set. Quality assurance systems had not always been sufficiently robust to ensure problems in the running of the service were put right.

After the inspection the registered manager wrote to tell us that new and more detailed quality checks had been introduced. They said that this would better enable them to quickly put problems right and to ensure the smooth running of the service. In addition, an operations manager, subsequently appointed, was responsible for oversight of service quality and ensuring ongoing audits and action plans identified and addressed any shortfalls.

At the present inspection we found systems and processes used to monitor and evaluate the operation of the service had been strengthened. The registered manager and provider had introduced some additional quality checks as well as commissioning an independent audit. Detailed audits looked at each aspect of the service to ensure people reliably received care that met their needs, expectations and preferences. Existing quality checks in place at our last inspection were further developed and more comprehensive. However, we identified one aspect, to address shortfalls in the records of application of topical creams in a recent action plan was detailed as completed when, in fact, work was ongoing to ensure measures in place were adopted as everyday practice for all staff. We further noted correct completion of cream charts was not included in current audit processes. We discussed this with registered and operations manager and highlighted this concern. Given this shortfall, developments in quality assurance processes had not been wholly successful. However, although further development was required, the improvements made in monitoring and resolving problems in the running of the service had resulted in sufficient progress being made to meet the previously breached regulation.

A number of arrangements had been made to support people who lived in the service and their relatives to suggest improvements to their home. These included being invited to attend regular residents' meetings at which people were offered the opportunity to give feedback about their experience of living in Mandalay Care Home. People, their relatives, staff, health and social care professionals visiting the service were also sent surveys about their view of the home. There were a number of examples of suggested improvements. One of these involved the recent replacement of a carpet as some people found it looked dated. Where menu and activity suggestions were made, these were quickly put into effect.

Everyone spoken with considered the service to be well run. One visitor told us, "The staff and management team are never too busy to listen, I've come to know them all well and feel I could always speak with them." One person commented, "We have everything we need, I do think the place is well run. If change was needed, I have no doubt they would listen and act favourably." Each person we spoke with was complimentary about the management of the service.

Staff felt well supported, there were a number of systems and processes to help care staff to be clear about their responsibilities. This included there always being a senior person on duty who was in charge of each shift. Care staff could also contact the manager or the deputy manager during out of office hours if they needed advice or assistance. Care staff told us that they were confident that they could speak to the registered manager if they had any concerns about people not receiving safe care. They told us they were confident that any concerns they raised would be taken seriously so that action could quickly be taken to keep people safe. These measures all contributed to care staff being suitably supported to care for people in the right way.

The service worked in partnership with other agencies. There were examples to confirm the registered manager recognised the importance of ensuring that people received 'joined-up' care. This was demonstrated when working in partnership with health care professionals, such as the mental health team, care managers and speech and language therapists. The registered manager and key staff attended workshops where they met with other service providers to receive training about national initiatives in the provision of good practice. The service also worked with the local community and education providers and displayed certificates to recognise their work in supporting some people with learning disabilities who received work experience at the service.

The registered manager understood their regulatory responsibilities. Services that provide health and social care to people are required to inform CQC of events that happen, such as a serious accident, so CQC can check that appropriate action was taken to prevent people from further harm. The registered manager notified CQC and the local authority in a timely manner.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The most recent CQC report was displayed in the service and a link to the latest report was on the provider's website in line with guidance.