Runwood Homes Limited

Mulberry Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Mulberry Court is a residential care home that was providing personal care and accommodation for 69 people aged 65 and over at the time of this inspection.

Following the last inspection, we met with the provider to confirm the providers action plan to show what they would do and by when to improve the key questions of Safe, Effective, Caring, Responsive, and Well Led to at least good. However, we found at this inspection the provider had failed to achieve this.

People's experience was poor living at Mulberry Court. There had been substantiated concerns from the local authority about neglect and acts of omission. The people who we spoke with did not speak very positively about the service. We had concerns that people were not always safe who were at risk of falls, those who were an unhealthy weight, and those who needed certain medicines. Staff did not always respond to safeguarding concerns in a safe way. People's dignity and comfort was not always promoted. Staff did not engage with people in way which demonstrated that they knew the people they were looking after. There were no activities or events taking place to help people enjoy life at the home. The home looked tired and uncared for. The management team and the provider had ineffective systems or no systems at all to test and ensure that people were safe, well cared for, and led meaningful lives at the home.

The last rating of the home was Inadequate this report was published on 25 July 2018. For more details please see the full report on www.cqc.org.uk

We inspected in January 2019 because the home was placed in Special Measures at the last inspection which means we must return in six months to check the service again. We were aware before the inspection of concerns raised by other professionals.

Full information about the CQC's regulatory response to the more serious concerns found at inspections and appeals is added to reports after any representations or appeals have been concluded.

The overall rating of this service is Inadequate and the service therefore remains in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their

registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our Effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our Caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Mulberry Court

Detailed findings

Background to this inspection

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

The inspection took place on 23 January 2019, this was within six months from the last inspection when the service was rated Inadequate and placed in special measures. There were also concerns raised by the local authority and the CCG before the inspection took place.

The inspection team was made up of two inspectors, an inspection manager, an assistant inspector, and a pharmacist inspector. A nurse specialist advisor in relation to falls management and nutrition and two Experts by Experience were also part of the inspection team. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. These Experts by Experience specialised in dementia care.

Mulberry Court is a residential care home which offers accommodation for up to 84 people. The service did not have a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Before the inspection we had been in contact with a representative from the local authority quality assurance team, the safeguarding team and the Clinical Commissioning Group (CCG) which is a team of health professionals. We looked at the notifications that the manager had sent us in the six months. Notifications are about important events that, by law the provider must send to us.

We did not use information the provider sent us in the Provider Information Return as we had seen this before the last inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We did however review the action plan we asked the provider to complete following the last inspection. We found that this had not been adhered to.

During the inspection we spoke with 15 people who lived at the home, 8 people's relatives, four members of staff, the deputy manager, the manager of the home, and the governance director for the provider. We looked at the care records of ten people, and the medicines records of people at the home. We also looked at the recruitment records for three members of staff. During our visit we completed observations of staff practice and interactions between people at the home and the staff. We also reviewed the audits and safety records completed at the home.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

We inspected Mulberry Court in May 2018 and rated the home Inadequate in safe. We found legal breaches in the Health and Social Care Act 2008. This was due to poor moving and handling of people by staff; A delay in a member of staff raising a safeguarding concern; Poor analysis post incidents and accidents and concerns with infection control. At this inspection in January 2019 improvements had not been made and we also identified new concerns.

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Using medicines safely

● The provider did not have safe systems in place to monitor the administration of medicines. We found one medication room was poorly organised which increased the risk of medication errors. One person had been prescribed anti biotics. This medicine could not be found for some time. A person's medication administration record (MAR) could not be found for 40 minutes. Everyone's prescribed creams were placed together in one medication room in a large open box. This increased the risk of staff making an error and placing the wrong cream on the wrong person. Some prescribed creams can harm a person if they are mixed. For example, if type A is placed on a person and accidently later type B is placed on a person.

The management of the home did not have safe and effective systems for monitoring the use of medicines which required stricter controls. One person's medicine had not been recorded in the records book. The purpose of this record is to help the management team to monitor the use and check the stock of these types of medicines. The provider had a policy for the monitoring of these medicines which the management team were not following. For example, one record book had not been checked since November 2018, but this should be weekly. Returned drugs were not signed for by the pharmacist. These returns were also not always dated. One record book had not been stored in a secure designated place which meant staff could not find it for over an hour.

People's 'as required' medicine protocols to guide staff when they should administer and offer these types of medicines had not been reviewed since 2013. These guidelines did not give staff clear guidance of when they should administer pain control as required medication for people who could not communicate with staff;. Such as people living with advanced dementia. We noted that a high number of pain control medication was not administered to people. The management team was not reviewing this or checking that people were getting their pain medication when they needed it.

The audits of medication administration were not effective checks to ensure medication was stored and administered safely as they had not identified these issues.

We therefore concluded that people were at risk of harm in relation to the administration of their prescribed

medicines.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong;

● We found that the management team had not implemented or used effective systems in a timely way. This was for monitoring risks to people's safety who were at risk of being an unhealthy weight. For example, the management team had introduced in December 2018 a way of checking if people had lost or gained weight. This record stated that one person had weighed more than this person's weight record in their care documents. It was unclear which record was accurate. This showed us that this new system was not effective. This person's need should have been being monitored more closely but this had not happened. We later spoke with the manager about this, who was not aware of this situation. From the information they told us verbally, we saw that delays had taken place in getting this person the help they needed.

During this inspection we also found that the systems to manage falls prevention were also not effective or robust. Staff were unclear about when people were to be referred to a specialist falls team. A member of the management team said, "It is on the second fall as standard practice." This is not good practice as it may be necessary to refer a person to the falls team after their first fall, to prevent another fall. The management team were not able to evidence to us they had completed any referrals to professionals to respond to this risk. The management team were not routinely checking all the appropriate action was being taken to mitigate individuals risk of falling and considering if other action could be taken. For example, it was identified that one person often forgot to walk with their frame. No work was completed to try and find a potential solution to this.

There had been two recently concluded safeguarding investigations which involved two people who were living at the home. The local authority safeguarding team had concluded that it was likely these individuals experienced neglect. Despite this, strong systems were not in place to manage people's safety in these areas. This placed people at risk of further harm.

People had risk assessments in place but we found that some people's risk assessments were not complete. For example, one person was at risk of being breathless, they did not have a risk assessment for this. Staff could also not locate this person's inhaler for some time. A plan had not been created to manage this risk. A person occasionally went out of the home alone, there was no clear plan to manage this. There was no risk assessment for this.

There were records which evidenced when an accident or incident took place. Although, these identified what had happened they did not show what action the management team had taken to respond to these and try and prevent them from happening again. The management team did not have a system to monitor or check that the action taken was sufficient.

One person was being monitored daily as they had harmed others and been harmed themselves. There was a gap in the completion of this monitoring record for four days when no observations had been recorded. When an incident occurred, there was no review of this, post incident to check people were safe. Or to see if the staff and the management team could take certain actions to try and prevent it from happening again. There was no check by the management team to see if this system was working, or if it could be improved upon.

Preventing and controlling infection

● We identified infection control risks. In one lounge we found some bodily fluid on a pressure cushion on

an armchair. We needed to inform the management team for this to be cleaned. We also found bodily fluid and dried matter on a person's crash mat by their bed in the morning. This was still present on this mat in the afternoon even though a member of staff had moved the mat. There were multiple dents on furniture and paintwork which could lead to growth of bacteria, which could make people unwell. Some furniture was ripped or had stains on it. In one lounge we saw staff encouraging people to wash their hands with bacterial wipes before their lunch. However, this did not happen in all the lounges and the dining rooms. We noted a discarded food protector left on a trolley and staff in one dining room used aprons when they supported people to eat, these were hung up after use, rather than being laundered.

The above issues constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● A person had recently returned from hospital with multiple marks on their body. No action had been taken to respond to this potential sign of abuse. The member of staff who identified this should have told the manager and raised a safeguarding referral to the local authority. We were told that lessons were learnt from this. There was a notice saying a new protocol will be in place for staff to follow. Given the potential risks associated with this, it was unclear why action had not been taken sooner to ensure this did not happen again.

We found a further incident where one people experienced harm, which should have been referred to the local authority safeguarding team, but it was not. This involved a person being assaulted. This event had been documented by staff but they had not taken action and alerted the management team to raise a safeguarding referral.

When we spoke with staff they told us what abuse could generally look like, and how they would tell a manager if they had concerns. However, not all the staff we spoke with knew who the outside agencies were who they could also report their concerns to. One member of staff said they would ask the citizens advice bureau. This was despite the fact there were posters adverting the local authority safeguarding team, about the home. Staff should have a clear understanding of this, the management team should be checking staff have a full knowledge of how to protect people from abuse, but they were not. Staff received training on safeguarding people from harm but this training was not always effective.

Staff also did not have a clear understanding or knowledge of how neglect could be abusive. There had been two recent safeguarding investigations about two people experiencing neglect at the home, and a serious safeguarding event which occurred in 2017 at the home. This also told us that the management team were not supporting staff to learn from errors made in the past.

The above issues constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some safety checks taking place to promote people's safety. These included regular checks on equipment used at the home to support people to mobilise and transfer from one position to another. There had been a recent fire assessment completed by a fire specialist organisation. There was various testing taking place of the fire equipment at the home. People had emergency evacuation plans in place. However, some of these had not been reviewed for some time. For example, two people's plans were completed in August 2017 and had not been reviewed since. This is important as their needs may have changed.

There was an emergency plan for the home. However, this lacked a meaningful plan about how to respond to severe weather and a reduction of staffing numbers. There was also no accompanying evidence to show that staff who may be needed to respond to an emergency, knew the plan and where it was located.

Staffing and recruitment

● Staff recruitment checks were in place for the staff records which we looked at. Although the local authority had recently identified one member of staff whose staff records showed that they had two criminal convictions. The management team had not responded to this by risk assessing this situation and putting a plan in place, to promote people's safety.

People and their relatives told us about their views of the staffing levels. One person's relative said, "I tend to come in the evenings and the staff levels vary, there is often only one [member of staff] in the lounge." Another person's relative said, "Sometimes there is no care staff in the lounge and it can be worrying as no one is about."

We observed that there were suitable numbers of staff during most parts of the day to meet people's needs. However, we did observe that at lunch time in one lounge there was a poor deployment of staff. For example, at one point there was one member of staff supporting one person to eat, but another person needed help but this was not identified and managed appropriately. To meet people's needs in this lounge and in a safe way, more staff were needed in this lounge, at this time.

People told us that they felt safe. One person said, "I think I am safe. Once I lock my bedroom door at night I'm fine. It's all ok so far." Another person said, "I'm safe enough here. I don't think about it. I'm on the top floor. The doors and windows are secure. I'm safe enough. Usually the staff are very good so no concerns there."

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

We inspected Mulberry Court in May 2018 and rated effective as Inadequate. There were breaches of the legal requirements of the Health and Social Care Act 2008. This was in relation to poor training and competency checks for staff. A chaotic meal experience and people being supported to eat quickly. Delayed response to people who were under weight. Poor systems to check people were eating enough. Staff did not seek people's consent and did not understand what this meant. We found this area had improved in terms of seeking people's permission. However, we found improvements had not been made in all these other areas.

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● Before we inspected the home there had been some concerns raised by the local authority safeguarding team about how people's fluid intake was managed. The management team told us about plans which were now in place to promote people's fluid in-take. However, we observed inconsistences with staff practice in this area. In one lounge drinks were provided, but staff only encouraged people to drink them on two occasions from late morning to 13:45. These were people who were living with dementia and needed support in this way. Alternatively, in another lounge and dining room staff were seen to frequently encourage people to drink.

The NHS food specialist team 'Food First' visited the home before our inspection. They found that the management team had not been effectively monitoring those at risk of being an unhealthy weight. We also found significant shortfalls in this area.

For two people who were at high risk of being an unhealthy weight, there was no care plan for staff to be following to manage this need for these people. This also meant the management team had no completed records of information about these people's needs for the management staff to check if these people's needs were being met in this area. The management team had not identified this shortfall. No referrals or timely referrals had been made to a specialist nutritional professional. For one person their care plan review stated no change, but there had been changes for this person, they had lost more weight. This person's food record did not show that their food was being enriched to help them gain weight.

In another person's record it made reference to guidance given by a GP, but their food record did not show that this advice from the GP was being followed. No specialist advice had been sought for this person's

nutritional needs.

One person's care record which detailed their monthly weights differed from the weights the management team had for this person. There was a delay in seeking professional guidance for this person. Their safety was not being promoted.

The management team told us that referrals had been made, but they could not evidence this. No interim measures were put in place for these people when they first started losing weight to promote weight gain. No one was monitoring the outcome of the referrals and advocating on the person's behalf when there was a delay. People's care plans were not being updated and checked by the management team.

Based on this and the systems the management team used, people who were at risk of being an unhealthy weight were not being supported in a safe and timely way at the home.

One person was living with advanced dementia and needed assistance to eat. We saw that the member of staff consistently put heaped amounts of food on a desert spoon into this person's mouth. This member of staff did not talk to this person or check they were ok. During their meal this person winced as they ate the food, this member of staff did not react to this. Later this person indicated that they wanted more to eat, this was ignored by a member of staff.

Another person said they wanted some help to eat their food. A member of staff cut up their meat, but only sliced the meat in half. Later, when only one member of staff was present and who had their back to this person, they took a large slice of meat and put it in their mouth in one go. We needed to advise the member of staff about this. They then cut this person's meet up into smaller pieces, but they did not check they were ok. This person continued to put heaped amounts of food into their mouth. They later tried to eat their sponge cake for desert, in one go. This person's eating style had not been captured in their assessment with a care plan to follow. The staff present were not checking for this behaviour and taking action. This person was at risk of choking.

People's dining experiences were poor. People sitting in the lounge were not supported to sit in a position which would help them to eat and drink. One person had been told about lunch but was not served their food for some time. They were becoming agitated saying in a loud voice, "Where's my dinner, where's my dinner?" The staff present at that time, did not act to support this person. In one dining room some people had just been given their main meal while other people on the same table as them, were eating their puddings.

People were not always supported to eat and drink foods which were presented in a way that encouraged choice with their food. Some people were shown two plated up meals to choose from, this is good practice to help people make a choice about their food. However, the people who had pureed diets were not showed two plated up meals. Staff did not tell these people what the food was. The cook had not used moulds so the pureed food resembled what it was. One member of staff put some pureed food on a spoon and said to the person, "I think this is the meat."

There were no attempts made in the lounges for people to try and enjoy their meal times as an experience. In one lounge people were not asked if they wanted to have the volume on the TV, or music on. Some people were asked if they wanted to go into the dining room. When they said no, staff asked again repeatedly. People were not asked if they wanted to have a clothes protector on. One person could not have one out of the two meal options, for medical reasons. They were not offered alternatives.

We concluded that People were not always being supported in a safe way to have enough to eat and drink. Or have a meaningful meal experience.

The above issues constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

When we asked people about their views on the food, people did not speak positively about it. One person said, "The food is OK really. Chef has a lot of meals to prepare." Another person said, "The food here is very boring." Another person said, "I did enjoy my lunch. Roast lamb. The food itself isn't too bad."

Staff support: induction, training, skills and experience

● The management team had a process to assess and test staff competency. However, we found that they were not consistently completing this work. When some staff competency checks were completed the records did not evidence how the assessor reached the conclusion that individual members of staff were competent in their work.

Staff received training but this was not always effective as people's support and care needs were not always met. When new staff started working they completed training. This training was usually delivered in one day. The amount of training was extensive. This meant that it was unlikely that this system encouraged staff to learn in an effective way. For example, in safeguarding people from abuse. We asked staff what they felt about the training. Most told us that it was "Good," but they could not tell us why they thought it was good.

The management team were not testing how effective the training provided was. We noted that when we inspected the home there were two dementia specialists supporting staff. This was positive but these specialists were not guiding staff or talking to staff to highlight why their approach was more effective.

We spoke with one member of staff who told us that the staff in general needed a lot of support and guidance in how to do their jobs well. We saw this take place at some points during our inspection, but often staff were not being directed or supported in terms of their practice. There was no management presence on the floor of the care home.

The staff rotas for the six weeks preceding our inspection showed that staff were routinely working a 14-hour day. We spoke with the manager about this. They told us that staff generally would not work three 14-hour shifts in a row. We saw that this was reflected in the rotas. However, the management team had not completed a recorded check that staff were functioning effectively when working a 14-hour shift and taking their breaks.

Ensuring consent to care and treatment in line with law and guidance

● 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.

The staff we spoke with told us how they encouraged and supported people to make their own decisions. Staff told us the techniques they used to support people as much as possible to make their own decisions. We also saw staff asking people where they wanted to sit at lunch time, and most, but not all, what they

wanted to eat.

Mental capacity assessments had been undertaken to determine what decisions people could or couldn't make about their day to day life. Although this had taken place the assessment records did not explain how they reached certain decisions. For example, one person was unable to communicate in English. The assessor said that the person could understand the information about a particular decision which needed to be made, but the assessor did not say how they knew this. It was unclear, in reality, how the assessor could make this judgement given this person's communication difficulties.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

The staff we spoke with had an understanding of what this meant, although most had not thought about what they would do if a person requested to leave the home, when it was not safe for them to do so.

During this inspection we had a concern raised by two different people. Their movements were being restricted by the manager. These people had the mental capacity to make the decision to leave the home. We needed to give advice about how these situations could be more effectively managed in the future, so that these people's movements were not restricted.

Adapting service, design, decoration to meet people's needs

● The layout and decoration of the home was not conducive to people who were living with dementia. There was a long mural on one floor painted in grey and black. On one corridor some tactile objects had been attached to the wall, but people did not respond to these, staff did not point these out to people. More work was needed to try and help people engage and identify their surroundings.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

We inspected Mulberry Court in May 2018 and rated the home as Inadequate in this area. There was a legal breach of the Health and Social Care Act 2008. People were not routinely being treated with dignity. When we inspected in January 2019 we found that some improvements had been made in this area. In terms of staff being consistently kinder and calmer with people who are frail. However, significant improvements were still needed.

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations were not met.

Respecting and promoting people's privacy, dignity and independence

● We asked people about how they were treated by the staff. One person said, "The staff are usually friendly and helpful. Some are cold. Some nasty and intimidating." A relative told us that staff can be caring, they said, "Yes, but some [staff] are better than others."

We found that people's dignity was not being promoted at the home. We entered two people's rooms and we noted there was stained marks on their sheets. One person's bed had been made by staff. Despite this there was dried blood stains on the sheets and these had not been removed. There were also stains on certain pieces of equipment in a person's bedroom. On one person's side table there was dried encrusted food stuck to this table. We spoke to a member of the management team about this. We later saw that these sheets had been removed, but other staining which we had not pointed out remained.

A person's dentures had been left in a bathroom cupboard, not placed into a container or covered. A person who was living with advanced dementia had been supported to sit in the lounge. They had been supported to transfer into their armchair with the use of a hoist. For the rest of the morning and afternoon they remained sitting in the sling which was used to transfer them. Staff did not check if the person was happy with this. Staff had not considered if this was promoting this person's dignity.

We noted that throughout the inspection staff were not routinely asking people if they wanted to use the bathroom. Even before and after lunch staff did not try and support people in this way. People who needed assistance to mobilise were not supported to do so to promote their mobility and independence.

A person had fallen into a deep sleep in an arm chair in the lounge. Their head was in an awkward position, meaning it was likely that their neck would hurt when they woke. Staff were present but did not respond to this. Eventually we intervened and told a member of staff about this. They went to try and wake this person up, who did not respond, we needed to speak with them again and suggested they used a cushion to support their head. We saw this member of staff lift and move their legs, this was done in an abrupt way.

Other people sat at awkward angles with their tables away from them. No member of staff responded to these situations.

A person had had an incontinence accident in one of the hallways. A person who had chosen not to wear anything on their feet who was living with dementia walked through this. A member of staff asked another member of staff to get a mop and bucket and stayed in the area to ensure no one slipped. However, they did not take action or say they would do so or request assistance for the person who had walked through this fluid.

Staff at various points of the day bounced inflated balloons in the air and threw them towards people to bounce back. We saw that staff gave no consideration to one person who was sitting in one lounge who did not want to play this game. One member of staff was bouncing a balloon to a person and it bounced on this other person's head. They said in a loud voice, "What is that, get off me get off me." This person was sat talking with their eyes closed. The member of staff then said to the person who was playing the game, "Look what you did." Even though the person had not done this. This was not kind or respectful.

On three occasions we noted that three different members of staff's tone sound frustrated when they spoke or responded to certain people. On one occasion two members of staff were leaving a person's bedroom, this person sounded distressed. One member of staff offered this person re-assurances and told them not to worry, however the other member of staff said something in a loud voice and in a derogatory way as they left this person's room.

The above issues constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During the inspection we were speaking with one person who told us how they had their own key to their room. They told us that it could open other people's rooms. At this point a member of the cleaning staff entered the room and asked to borrow it, to unlock the person's room next to them. This had the potential to undermine a person's privacy and was not good practice.

Ensuring people are well treated and supported; equality and diversity

● Except for people who needed support to eat their food, we observed that people were treated equally. However, we noted when we looked at some people's care documents that some people had diverse needs. For example, one person was a muslin and needed their food to be prepared and stored in a certain way. When we asked the manager about people's diverse needs. They did not know if people had any at the home. The management team was not routinely checking that these people's cultural needs were being met.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

We inspected Mulberry Court in May 2018 and rated this area as Requires Improvement. There was also a legal breach of the Health and Social Care Act 2008. People did not have person centred assessments and care plans. We were not confident people's diverse needs were being met. There were limited activities. At this inspection in January 2019 we still found that improvements were needed. This time we rated this area as Inadequate.

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

● We looked at a sample of people's care assessments which had recently been re-written. These had improved from the last inspection in May 2018. People's needs were captured and there was clear guidance for staff to follow in order to meet most people's physical needs. However, staff were not looking at these assessments. This is what staff had told us, and we did not see this practice taking place. The management team were not checking staff were aware of the plans to meet individual's needs, they were not testing or monitoring this.

Despite these assessments containing details about people's physical needs, these records lacked personal information about the person. In most cases the management team had not captured what people's likes and interests were. In some people's care assessments there was some information about people's interests but this was limited. Their past achievements and what they would like to achieve at this part of their life were also not identified.

People were not having meaningful and personal reviews of their care. People were not being asked if they enjoyed living at Mulberry Court or what changes they would like to see. Staff who knew people well and people's relatives were also not being involved in the review of people's care, especially those who were living with advanced dementia. No successful attempts were made to check if people's life and experiences of living in the home could be improved upon in some way.

We found that people did not have end of life plans in place. Often, these records would defer to the relative involved. The management team had made no attempts to capture important information to ensure that staff knew how to meet people's needs and wishes towards the end of people's lives. There was no plan or consideration about how the service would achieve this.

One person told us that, "There's not a lot of activities to do here really. I haven't spoken about it. My family visit and take me out. I'm OK really." One person's relative said, "[Relative's name] does not get much stimulation, some [staff] say hello some just walk past and do what they need to do. [Relative] has no one to

one input or entertainment." Another person's relative said, "It worries me that there is a lack of entertainment here, they [people in the home] always seem to be sitting about in the lounge."

From our observations during the inspection we found that people's day to day quality of life was poor. There were no activities or events taking place. The management team and the staff had not tried to explore what people's individual interests were, to create activities and events around these. Often staff would get an inflated balloon out or a beach ball and throw this towards people. This was the same at the last inspection. There was no consideration if people wanted to play this game. If cups containing tea or soft drinks needed to be moved away or if people felt comfortable with balls and balloons being thrown at them or near them.

We noted that the TV was always on with the sound off and subtitles on. No one was asked what they wanted to watch. The volume was not put on, and some people were positioned in a way so they could not see the TV. Music was sometimes put on, again people were not always asked what they wanted to listen to, often no attempts were made to try and involve people with this. For example, one member of staff was looking for a CD and said, "Oh, 'how we won the war'…. that will do." There was no thought if this was even relevant to the people in the room. Some people who were living with advanced dementia repeatedly rubbed their fingers together or touched their trousers. No member of staff thought to give them a tactile object to hold and touch.

Staff did not engage with people in a meaningful way. Staff did not chat or try and engage in light conversation or banter. We saw staff entering people's bedrooms to help them up for the day. These members of staff did not say 'Morning' or try and chat with people. There were some brief moments when people laughed or when staff spoke with people, but this was rare.

Staff did not consider if people were comfortable or wanted to mobilise or have a change of scenery. One person was in a wheelchair and was left in the middle of the lounge eating their toast. People were sat around them. They were at a right angle to the TV and they were being blinded by the sun shining through a window. Staff had not considered this person needs when eating their breakfast. People were not encouraged to use the bathroom. People who had legs bandaged or had swollen feet were not encouraged to elevate them or given a stool to prompt them to do so. One person told us, "I should be resting my legs. But I don't have a chair that allows that, so I have to go to bed and I don't want to do that. Both of my legs are back to square one again."

People's rooms were not always personalised unless individuals themselves or people's relatives had done this. Except for a small shelf with a few items on it, there was little to enable people to engage with their space. We found that some people had large cardboard boxes filled with various medical supplies in their bedroom in full view of the room.

The home looked tired and uncared for. Paintwork dented, curtains hung poorly. In one lounge a roller blind was left leaning against a window. Kitchenettes were messy. White boards, which told people the day of the week and season was were hard to see and were often some days out of date. No attempts were made to make daily routines such as lunch or having a hot drink and snack enjoyable or interesting.

The above issues constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns

● During the inspection we looked at the complaints which had been raised. We found that in some cases there was a lack of recorded evidence to show how the management team had responded to these. There was no evidence to show how they had learnt from these situations and how they would try and prevent similar or the same situations from happening again. A relative who we spoke with did not have confidence that complaints were responded to. They said, "I did make a complaint about a certain bank staff. Just not a good carer. I was given assurances they would not come back. So, I was really disappointed to see [member of staff] here on Christmas Day."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

When we inspected Mulberry Court in May 2018 we rated well led as Inadequate. There was a legal breach of the Health and Social Care Act 2008. The registered manager and the provider delivered ineffective leadership and had poor governance systems. At this inspection in January 2019 we still found that there was still poor leadership and poor systems to ensure people had good experiences whilst they lived at the home.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others;

● The management team and the provider had ineffective systems to ensure people were safe. In relation to falls management. When people are at risk of poor nutrition and being an unhealthy weight, and ensuring people received their prescribed medication. We therefore did not have full assurances that people were always safe in relation to these needs.

The management team and the provider was completing some audits in these areas but they were either not effective or they were not taking place. For example, the way the service monitored the use and storage of certain medicines was not safe. The medication audit did not identify the obvious short falls in this area. The management team was not evidencing referrals made to specialist health professionals in relation to falls and nutrition. The audit did not identify this issue. There was no meaningful check that robust measures were in place to promote these people's safety and well-being in these areas. Accidents and incidents records did not show what action was taken to prevent a similar event from happening again. The audits did not highlight these shortfalls and the management team had not put in new systems, to correct these shortfalls.

The provider and the management team were not looking at people's daily experiences of living at Mulberry Court to see if these people's lives could be improved upon. The provider was not checking the number of safeguarding events raised and looking at these to see if improvements could be made. There had been a high number of deaths at the home in the last 12 months. The provider was not looking at these cases to check and seek assurances about this statistic. There were no plans in place to address these shortfalls.

We also found that the management team and the provider were not learning from past mistakes. Various issues were raised at the last inspection which have not been corrected or improved upon. This related to the systems to check staff were competent and functioning well in their work. Testing how effective the training was. Poor meals experiences, limited social opportunities, staff promoting people's dignity, and

people's experiences at the home.

Even recently there has been input from outside organisations, the local authority, CCG (clinical commissioning group) and Food First. Improvements had not taken place. Strong processes were not in place to monitor this within the home. Food First found shortfalls in how the home checked people were safe regarding their weight. Better systems were not developed because of this input from these other agencies.

There had been no registered manager in place since August 2018. Since the previous registered manager deregistered in August 2018 there had been three acting managers. The provider had not ensured that there was continuity of leadership to support the management of the home following the previous Inadequate rating.

There was not an open, transparent culture at the home. We were told by some staff that they were told to tell us, "Everything was fine" however, this was not the view of all the staff we spoke with. Concerns had been raised about staff retrospectively completing documents relating to people's needs. A member of the administration staff had tried to take copies of the pharmacy inspectors notes without seeking their permission. A member of staff had tried to tell us that a person had only recently sat in an awkward position, when this was not the case. The management team was not looking at ways to build morale in the home. The provider was not monitoring the culture of the home.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The management team and the provider were not promoting high quality care to the people who lived at Mulberry Court. No efforts were made to review and consider people's daily life experiences and make improvements in these areas.

The above issues constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had not been notified about the outcome of two safeguarding investigations concerning people's safety at the home. In addition, we had also not been notified about a safeguarding concern involving a person being harmed at the home. The provider by law should have ensured we were informed about the two substantiated safeguarding events. This limited our ability to alert other organisations who could support people to be safe.

The above issues constituted a breach of Registration 18 Regulations 2009 (Part 4).

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 HSCA (Registration) Regulations 2008 (part 4): Notifications of other incidents. The provider had failed to notify the commission about all the important events they must notify us about by law. Regulation 18 (1) and (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (RA) Regulations 2014: Person centred care. The provider had not ensured that the care and support people received meet their needs and reflect their preferences. Regulation 9 (1) (a) (b) (c) (3) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (RA) Regulations 2014: Dignity and respect The provider had not ensured that care and treatment was always provided in a respectful and dignified way.

Regulation 10 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The provider had not ensured that care and treatment was provided in a safe way. They had not taken appropriate actions to mitigate key risk in relation to falls, nutrition and medication management. Regulation 12 (1) and (2) (a) (b) (c) (g) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA 2008 (RA) Regulations 2014: Safeguarding service users from abuse and improper treatment. The provider had not ensured that people always protected from abuse. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 HSCA 2008 (RA) Regulations 2014: Meeting nutritional and hydration needs The provider had not ensured that people's nutritional needs were always being met and monitored in a safe way. Regulation 14 (1) (2) (b) 4 (a)