Complete Care Services Limited

Mulberry House

Inspection report

120 Barton Road
Luton
Bedfordshire
LU3 2BD

Tel: 01582570569
Website: www.completecare.org.uk

Date of inspection visit:
01 February 2018
02 February 2018

Date of publication:
11 April 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service in January 2016 and rated the home as Good overall. When we inspected the service on 1 and 2 February 2018 we rated the service as Inadequate overall. This is the first time Mulberry House has been rated as Inadequate overall. This inspection was announced the day before we visited. This was to ensure a member of staff would be present to let us into the home.

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

Mulberry House provides personal care and accommodation for people who have a range of learning disabilities. Mulberry House can provide care for up to 8 adults. At the time of the inspection 8 people were living at the home. Mulberry House comprises of accommodation over two floors.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy

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

When we visited the home we found there were issues with how the service promoted people's safety. Timely action was not taken to repair some fire safety equipment. Checks to ensure people were safe in the presence of staff were not always completed or in a robust way. There was a lack of clear leadership at the home. Posts relating to the leadership of the service remained vacant with no plan in place to respond to this issue.

The provider (owner) had not responded in a timely way to requests from the registered manager about

making improvements to the home. They did not show a commitment to help the service to make improvements. The building looked uncared for in places. There were delays in making real plans to improve the home. This made us question how the provider valued the people living in the home.

The quality monitoring audits were not robust. We had not always been informed about the important events which we should be notified about, by law.

Staff did not receive competency checks to ensure they had the skills and knowledge to do their work. Staff were critical in how their training was delivered and the registered manager and provider were not checking if the training was effective. Not all staff received regular and complete training.

There was a lack of activities which people engaged with at the home, although the home was starting to work on this issue. There were no planned events and people were not being supported to realise their ambitions and interests.

These issues constituted a breach in the legal requirements of the law. There was a breach of Regulation 12, 19, 18, 10, 9, and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was also a breach of the Registration Regulations (18). You can see what action we asked the provider to take at the back of the full version of the report.

Staff did not have a clear understanding about the process they could follow in reporting potential abuse and harm outside of the home. Staff also did not know how to fully respond if people experienced discrimination. There were no clear systems in place to support staff to respond to these potential situations which also promoted people's rights at the home.

People received their medicines as prescribed and people were supported to access health appointments. People had risk assessments in place but these were not always up to date and did not fully explore the risks which people faced. With a plan of action to follow to mitigate and respond to these risks.

The home did not always promote healthier foods and lifestyles at the home. People were not always supported to drink frequently during the day.

Staff were promoting people's freedom of choice but this was not done for all the people in the service. For some people, staff were also potentially restricting their liberties and rights at the home.

The staff at Mulberry House were kind and caring towards the people who lived at the home. Staff spoke with people as adults and the service made attempts to encourage people's independence with their day to day needs.

Staff and the registered manager spoke about their commitment to the service. The registered manager told us that they were motivated to make improvements.

The overall rating for this service is 'Inadequate' and the service is therefore 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.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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 always safe.

Faulty fire related equipment was not being fixed in a timely way.

Risks were not always being managed in a safe way.

Staff knowledge about protecting people from potential abuse and discrimination was not robust.

Staffing levels were not always sufficient.

There was a lack of daily managerial oversight of the service.

Security checks on new staff were not always in place when they started working at the home.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff competency checks were not in place.

There were shortfalls with staff training.

The effectiveness of staff training was not tested.

The service did not always promote healthy eating and lifestyles.

One person's liberties were not always being promoted by the service.

People were supported to access health services.

Is the service caring?

Requires Improvement

The service was not always caring.

The condition of the home looked uncared for and was in a poor state of decoration.

Staff needed more support about how to respond to people when they became distressed.

Staff were kind and treated people as adults.

People were encouraged to be independent with elements of their day to day life.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of meaningful activities and planned events taking place.

People's ambitions were not being explored in real terms.

People's individual communication needs were not always being met.

People's needs and reviews of their support were not always fully explored.

Is the service well-led?

Inadequate

The service was not well led.

There was not always a clear leadership of the service.

Staff found it difficult to raise issues about the service.

The provider was not responding to the need to make improvements in a timely way.

The provider audits were not robust and did not support the service to do better.

There were limited links with the community.

Mulberry House

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 checked 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.

The inspection site visit started on 1 February 2018 and ended on 2 February 2018. We gave the service 19 hours' notice because the home was small and people could be out during the day. So we wanted to ensure a member of staff would be present to let us in.

The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance the expert-by-experience has personal experience of caring and supporting a person who had a learning disability.

Before the inspection we made contact with the local authorities' contracts team and safeguarding team. We asked them for their views on the service. We looked at the notifications that the registered manager had sent us over the last two years. Notifications are about important events that the provider must send us by law.

During the inspection we spoke with five people who lived at the home, four people's relatives, five members of care staff, staff supporting the management of the home and the registered manager. We looked at the care records of three people, the medicines records of four people and 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.

We received a Provider Information Return report. This is information we require the provider 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 took this into account when we inspected the service and made the judgements in the report.

Inadequate

Our findings

We visited Mulberry House in January 2016 and found at that time that people were supported to be safe. However, when we visited in February 2018 we found that some improvements were required.

During this inspection a member of staff tested the fire alarms. They found that two fire doors were slow to close and one fire door did not close. We heard them say to another member of staff that this had been recorded in the maintenance book. When we looked at the maintenance log we could see that this issue with these doors had been identified two weeks before on 18th January. But this issue had not been resolved. No plan was put in place to fix this problem. No one was contacted and a date agreed to come and resolve this issue. We raised this with the registered manager. They said that the maintenance person comes once a month and was not due to come yet. No plan had been put in place to fix the fire door when this was identified. Other than wait for the maintenance person to complete their routine visit. We explained the importance of ensuring this fire related equipment worked. We later made contact with the service; they told us that the fire doors were fixed on 5 February 2018.

One person went out into the community independently. They enjoyed doing this and this was a positive element to the service, that this person's freedom was not being restricted. However, on two recent occasions this person had got lost on their return home. On one occasion they knocked on a person's front door they did not know, to ask for help. This person then telephoned Mulberry House. No plan was put in place to help ensure that this person did not get lost returning to the home in the future. There was no process for staff to follow if this person did not return home apart from call 999. Staff had not worked with this person to ensure they would not get lost again or tried different options to support this person to contact the home or go to a safe place if they did get lost again. This put the person at risk of harm.

We looked at the accident and incident reports produced by staff. We noted a pattern relating to one person who had had three falls and a potential 'near miss.' A member of staff had spoken with this person to see if they wanted staff to be present when this person was most at risk of falling, but they had declined. No other practical action was taken to try and reduce this risk of falls. We looked at this person's care record and risk assessment. This person's risk assessment had not been updated with a course of action for staff to follow to reduce this risk. This person later had a fall and spent time in hospital. The circumstances to this fall were different from before but again this did not result in a full review of their mobility and safety. This person had to negotiate a stair case to get to and from their bedroom. The stair rail had an area where one could not easily place one of their hands to steady themselves. We spoke with a member of staff who told us what they

were doing to try and reduce the risk of falls for this person in the future. They said staff were to carry this person's bag when they go upstairs. We saw this happen on one occasion. We were later shown a risk assessment which identified this risk of using the stairs. However, it did not explore how this risk could be reduced to ensure this person's safety. Appropriate and timely action had not been taken to reduce this risk. The day to day risk had not been considered with short term options explored considering their history with falls. We also spoke with a relative who said, "It's an accident waiting to happen."

When we looked at people's care records we could see that people had risk assessments in place. These did identify the risks which people faced. However, they did not always give clear guidance for staff about how to mitigate or respond to these risks. One person was living with epilepsy. There was no plan about how this person can present as unwell in relation to this condition. Or information about what staff must do if they believed this person may have a seizure or if they have had a seizure. Another person was at risk of falls. This risk was not explored with a plan of action to manage this risk. A person was at risk when out in the community in terms of their road safety. This person's risk assessment did say that staff were to "Encourage" this person to be alert and engage with their surroundings. However, it did not say how to encourage this person to do this.

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

At this inspection we also looked at the recruitment practices for new staff. We looked at three staff recruitment files. We found that these members of staff had completed Disclosure and Baring Service (DBS) checks. These members of staff also had two references. However, out of the three staff records we looked at none had full employment histories with gaps explained. Staff applications did not ask for this information. One staff file only had one proof of their identity recorded.

We were told that some new staff started at the home without a DBS completed check. We were told that these new members of staff do not provide care independently and they "Shadow" staff. We were also told that these new members of staff look through people's care records. This is not safe practice. At the very least these members of staff are privy to sensitive information and were in the company of vulnerable people without all the safety checks being completed. We advised the registered manager about this and they advised us that they would stop this practice straight away.

The above issues constituted a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we visited the home we were told that the registered manager, had assessed that three members of staff should be working on the day shifts. With two members of staff at night. This is what the registered manager had decided was an adequate level of staff, to ensure people were safe and their needs were met. However, when we spoke with relatives and staff we were told that sometimes there are only two members of staff on duty. We looked at the last six weeks 'worked on' rotas and found that there were times when this was the case. We were told by one relative that this had concerned them. One member of staff said, "This is not enough staff to give people good care." The staff and relatives we spoke with also added that recently the staffing level had improved. Agency staff were used when there was a shortfall of staff numbers. We could also see on the rotas that there were consistently three members of staff on shift towards the end of the six week rota. However, some of the staff we spoke with were not confident this staffing issue would not happen again.

During our two days at the service we noted that there were times that people were expressing high energy.

There were times when two members of staff were needed to be in the kitchen near meal times to ensure people's needs were met and people were safe, but only one member of staff was available at these times. Day staff worked a 12.5 hour shift and people were in regular need of staff's attention.

Considering this issue of low staffing levels, we could not find any evidence to say this had a negative impact on people, and made them unsafe. However, this could be a risk in the future, if this practice continued.

There was no clear leader of the shift. The registered manager worked three days a week and there was a vacant deputy manager post which had not been filled. On one of the days we visited Mulberry House the administrative person did support staff and was present in the communal part of the home. On the second day the home's quality monitoring member of staff was present because we were visiting the home. On both of these days we saw these senior members of staff supporting and directing staff with their care tasks and duties. However, there was no senior member of staff rostered to lead the shift. We were told that on one of our days at the home the staff team were, "One of the weakest" and would benefit from someone leading the shift. Although we did not see any significant issues in relation to staff practice. We did see these senior members of staff supporting and directing staff and these members of staff appeared to benefit from this input.

We spoke with the administrative person who said the service had tried to encourage experienced staff to apply for the role of senior, but no one had wanted to. We asked what the alternative plan was and we found that there was no such plan. Given all of this information and the recent historic issues with staffing we concluded that there were issues with the staffing levels, how the shifts were organised and led.

The above issues constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we spoke with staff. We asked them about their understanding of how to protect people from potential harm and abuse. All the staff we spoke with explained to us how they would spot the potential signs of abuse. Staff said they would tell the administrative member of staff or quality monitoring member of staff if available or the manager. We were told that there is an 'on-call' system in place when there is no senior staff at the home. One member of staff told us that they did receive support via the on call system before.

Staff also said they would tell an organisation outside of the home if they did not believe action was being taken. However, only one member of staff out of the group of staff we spoke with knew this organisation was the local authority. Considering this is such an important subject, staff should have a clear and firm understanding, of the agencies they can contact if they have concerns about abuse.

We also asked staff about their understanding of discrimination. Staff struggled to talk to us about this topic and relate it to the people they supported. All the staff we spoke with about discrimination said that they had not heard of 'protected characteristics' and how these could relate to the people at the home. We asked staff what they would do if a person they supported experienced discrimination when they went out into the community. They told us how they would protect that person from immediate harm. However, they did not know of the other actions they could take to address this issue. There was no agreed protocol in place or understanding in relation to addressing 'hate incidents' with the police. The service was not aware and championing people's rights in relation to potential discrimination.

Some people who lived at the home could express behaviour which challenged other people. We looked at four people's care records and found information about this. These records described what this behaviour

looked like, triggers to this, and how staff can deescalate these situations.

During our visit to the home we noted that the service was checking that people's electrical items were safe. These items were in people's bedrooms and in the communal parts of the home. There were weekly tests of the fire alarm. Other fire related equipment and the building had been tested by an outside organisation. The water temperatures were being checked on a weekly basis in people's bathrooms. The service was testing for Legionella. This is a water born virus that can cause people to become unwell. However, we went into one person's bathroom and found that a towel rack was on and this was very hot and could potentially cause an injury. We told a member of staff about this who sought advice and turned this off. They said they had logged this with the maintenance person to fix. But this issue had not been identified by staff. The home had access to a vehicle to take people out. The registered manager said that staff completed basic safety checks when they used the car, but there was no documentation to support this.

When we were at the home we completed an audit of people's medicines. We looked at a sample of four people's Medication Administration Records (MARs). These were completed fully with no gaps. Staff had recorded and stated the reason when a person had an 'as required' (PRN) medicine. There was guidance for staff to follow regarding people's mood controlling medicines. When we looked at the medicines given this totalled with people's MAR charts. We could see that the staff were monitoring the temperatures of where the medicines were being stored. However, we noted that some people's prescribed creams were in their bedrooms. These creams should not be stored above 25 degrees. But the temperatures of these rooms were not being monitored. This is important because if these medicines are kept above the recommended temperatures, this could affect the effectiveness of these medicines. We later spoke with the registered manager about this who told us that this practice has now stopped and staff are monitoring the temperatures of where these medicines are being stored.

We looked at one person's record who had been prescribed mood controlling medicines. They had six monthly reviews led by health professionals. These meetings involved two members of staff who supported this person and a social care professional. This is good practice to ensure people are not overly medicated.

During our time at the home we were present when a member of staff administered a person one of their medicines. This member of staff signed the MAR chart before they had checked the person had taken their medicine. This person still had their tablet in their hand. Shortly after this we saw this person chew their tablet and take some water. This member of staff was distracted. They were putting on their coat to go out with another person who lived at the home. This is not a safe way to administer people their medicines. We looked at the staff medication competency checks which were completed to ensure staff were sufficiently trained and competent to give people their medicines. These checks were completed on five occasions to ensure the registered manager was satisfied that staff were competent in this area. However, these checks had not identified this poor practice.

When we visited the home we observed a member of staff supporting with preparing lunch. We noted that they had not washed their hands before they started handling food, nor had the person who lived at the home who was helping them. We prompted them to do so. When they washed their hands it was with the water in the washing up bowl. There was no detergent in this water. This is not good infection control practice.

There were some people at the home who communicated in ways that we could not understand. When we asked people if they felt safe at the home, one person said, "Yes I do feel safe because the alarms are always tested. Staff have shown me where the fire alarm is." A person's relative said, "Yes I think [relative] is safe because they lock the doors and there is no other way in or out."

Requires Improvement

Our findings

We visited Mulberry House in January 2016 and found that the home was providing Good effective care to people. When we visited in February 2018 we found some areas where improvements were required.

When we visited the home we found that no attempts had been made to use equipment or technology to support people to live independently. Or to access information and support relevant to their needs and interests.

The staff we spoke with spoke positively about their inductions but some were critical of the training they received. Some staff said that the training they received during the year was boring and the way it was delivered did not stimulate them. Staff made references to "Dozing off" during the training and how the trainer, "Just reads the information." Training such as moving and handling and first aid was given as theory. Practical, hands on training in these areas was not provided. Some staff questioned how effective this training was.

When new staff started working at Mulberry House they were given training in areas such as infection control, safeguarding, first aid and health and safety. However, this was not provided in one period of time. For example, one member of staff started in June 2017 but did not have further induction training until July and August 2017. This meant that staff were supporting people without completing training in key areas.

We were shown a training programme for the staff. There were some gaps in this training. One member of staff had not had training in health and safety, Fire awareness, and infection control. Other training was provided to staff relevant to people's needs. Such as autism, epilepsy, and diabetes. Although this was positive this training had not been refreshed. Some members of staff completed this training in 2015. New staff who had started supporting people in the summer of 2017 did not have this training, and yet they were supporting people who had needs in these areas.

Staff who worked on 'bank' and were called upon when required did not have a record of their training. It was assumed that some bank staff had the knowledge and skills because they were also studying for health and social care subjects outside of this work. The registered manager said that some bank staff do go through a short induction refresher before they work again at the home, but they could not evidence this. Also, when bank staff were called upon at short notice it was not clear how this induction refresher could practically take place.

The registered manager with the exception of medication administration had no system to check if the training delivered was effective. Staff's understanding of the training they had received was not being tested or checked after the event.

Staff competency was not monitored or assessed with the exception of administration of medicines. There were no routine checks to see if staff had retained their training and were putting it into practice. There was no robust competency frame work which staff were assessed against which evidenced if staff met this competency standard. When we spoke with staff and observed their practice we identified issues with their knowledge and understanding in key areas. For example in safeguarding people from harm, responding to discrimination, good infection control and administration of medicines. The fact that there was not a lead on shift to support staff and address issues with staff practice, highlighted an additional need for strong competency checks to be in place.

The above issues constituted a further breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about their food and drinks. Most people were unable to communicate with us in ways we could understand. However, one person said, "I had Weetabix and tea for breakfast. I like that." Another person showed us the menu and nodded. They indicated their favourite foods. A person's relative said, "I think [name of relative] gets enough to eat, and [person] would soon let me know (if this was not the case)."

A member of staff told us about how people chose what they wanted to eat. People would be asked at 'residents meetings' about what they wanted to eat. Each week a person would be chosen for a 'Come Dine With Me' experience. Where they would choose the food for the evening meal and help cook this. Staff said that if people did not want what was offered they would be asked what they wanted and a member of staff would go and get this food from the local shops. We could see in people's care records that people had been asked their food likes and dislikes.

We had had some concerns raised about the home recently and one of these concerns was the amount of drinks people were being supported to have. There were set drink times which were fully adhered to on both days we visited. The registered manager had stated on a letter in the kitchen that people can be offered drinks in between these times. However, staff did not do this. We noted that people had gaps of 2 and 3 hours before they had another drink. We spoke with one member of staff who said that one person would drink and drink until this caused them to be unwell. However, the service had not considered smaller drinks for this person when they requested drinks. At 12:15pm a person asked for another drink, a member of staff said, "No, you've just had lunch and juice. Remember, now you wait till 3 0'clock for cake and cup of tea."

The service needed to make improvements about how they promoted healthy food. The administrative member of staff talked to us about how fresh fruit and vegetables were promoted by staff and were available with meals. On the first lunch time we observed everyone had a shop bought pork pie, Cornish pasty, and a bag of crisps. There had been no attempts made to provide some healthy alternatives or to make this meal healthier.

Alternatively people did have a fruit salad for pudding. However, one person did not want to eat this. A member of staff said, "You don't have to eat your fruit salad if you don't want to." No attempt was made to talk with the person about the benefits of eating this food. That evening rather than fresh vegetables, tinned vegetables were used and they were left boiling for some time. There was no pictorial information around the dining room about promoting healthy eating and life styles. The meal time experience was not

considered as a social activity and staff did not discuss this topic of healthy eating.

Two people were on fortified diets following specialist health involvement due to concerns raised by staff about them losing weight. Guidance was in the kitchen for staff to follow about how to do this. On these people's records it said to encourage snacks during the day. However, these people only had a snack twice a day which was the same as everyone else. On two occasions this was fruit rather than a high calorie snack. These people's portions were also the same as everyone else. On the second day people had a tined salmon in a white bread roll with cucumber. One roll was also offered to these two people.

We looked at these two people's weight charts. We noted that one person had not had their weight checked for two months. The previous month to this period they had lost weight. The other person had gained some weight but their weight was also not checked the following month. We spoke with the registered manager who said they had recognised this was happening and changed the system, so these people will have their weight monitored weekly. However, the previous forms did not include what a person's ideal weight should be nor did it give guidance for staff about how to respond when people's weight were not at healthy levels. The form did not prompt staff about what action they should take if this was the case. The registered manager had not considered these issues with their review of monitoring people's weight.

There was an eight week pictorial menu and one person talked us through this menu. Meals were well spaced and people appeared to enjoy them. However, the meal experience was not considered. People were not asked if they wanted the music playing that had been in the background since the morning. Staff did not chat and engage with people when they were eating even though they were sitting with them.

During our visit we looked at a sample of four care records. We noted that people were supported to health appointments at the hospital. The administrative and quality monitoring members of staff told us how they had concerns about one person's health. They told us what action had been taken and how they had had to advocate on this person's behalf to ensure they received the medical attention, they felt they needed. We later looked at this person's record which confirmed the medical appointments this person attended. These members of staff also showed us the 'medical books' which staff took with people to their hospital and doctor's appointments. These records contained key information about this person's social and physical needs. This information was aimed at assisting these health professionals in supporting these people.

At this inspection we spoke with a health professional. They spoke positively about how responsive staff were to a person's health needs. They said, "They [staff] are a good bunch, I have no concerns (regarding people's health needs)."

We considered the design and layout of the home. There were communal spaces and an outside space which people accessed during the time we visited. However, different options in relation to the main stair case had not been considered for one person who was living at the home and struggling to use the stairs.

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.

We asked some members of staff about their understanding of mental capacity. We received a mixed response. However, staff did tell us how they encouraged people to make their own decisions in relation to elements of their daily routines. We saw staff giving people options and asking people what they wanted to

do. One member of staff said, "I will hold two jumpers up and [Name] will pick one or shake their head and I will get two more until they are happy." However, in relation to other daily routines choice was not always explored for example drinks and people's foods and meeting people's social needs.

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 the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at one person's records who had been placed under a DoLS. We looked at their authorisation of DoLS from the local authority and we could see staff and the service were compliant with this. However, the staff was restricting one person from having access to their property and sometimes stopping them from smoking, when they requested to smoke. The registered manager and provider had not considered if their actions were a restriction of this person's liberty. They had not assessed their capacity to make these decisions or arranged for a best interest meeting to take place. When we later spoke with the registered manager after the inspection they told us of what was happening to address this issue.

When we asked the staff we spoke with about their understanding of DoLS it was clear that these members of staff did not have a basic understanding of what a DoLS was, even though some of the people they were supporting were placed under a DoLS. We concluded that improvements were required with how the service promoted people's liberties and choices.

Requires Improvement

Our findings

In January 2016 we inspected Mulberry House and found the service was caring. At this inspection in February 2018 we found there was an element of the service which were not caring, therefore we have rated this area as requires improvement.

We found that the general condition of some of the communal rooms and some people's bedrooms were in a poor state. Paint work was chipped and marked. People who did have windows in their en-suites did not have blinds or curtains to protect their dignity. . Two people did not have curtains or blinds at their bedroom windows. These people had self-adhesive frosting three quarters up their windows. The bathroom windows were mottled. People's basic privacy was protected, but this was not very caring or encouraged people to feel at home. People were not consulted about this. We noted other general repair issues when we went into people's rooms. Fronts of draws were missing in one person's bedroom furniture. Handles were missing in another person's furniture. A person's net curtain was sagging and their opened curtain was part hanging off the rail. Some people's grouting in their bathrooms were stained yellow. Some people's bathroom light cords were stained. Many of the double glazed windows had failed making it difficult to look outside. The home looked tired and uncared for in parts.

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

When we visited the home most people could not communicate with us in ways which we could understand. However, during our time at the home we noted that staff treated people in a kind and caring way. Staff spoke with people as an adult and generally at their eye level. When people became upset with one another staff calmed these situations in a gentle way. One person complained about another person going outside a lot. The member of staff said, "[Name of person] it's [person's] home too." Another person criticised another person for starting their lunch before people sat down, a member of staff said, "If [person] wants to start their lunch they can."

During our visit one person expressed that they were distressed. Staff's response when this person started to cry was limited. This person said, "I must not cry." Staff looked sympathetic but did not say or do anything. Another person became agitated and distressed in a loud way with another person and then directed this frustration at staff. Staff did not respond. Eventually the quality monitoring member of staff intervened and spoke with the person and suggested they came to the office and had a chat about it. When this person left

the room the other person expressed behaviour which according to their care assessment indicated distress. However staff continued with their tasks and did not respond to this.

We concluded that these responses were not about staff not being kind it was about staff not knowing how to react and support these individuals when they were distressed.

Most people were unable to communicate with us in ways which we could always understand. However we asked some people's relative's about their views of how their relatives were treated. One person's relative said, "[Relative] is very well looked after. I don't think it's put on when I am there watching. They're lovely staff and manager. My [relative] loves them and they do [relative]. Another person's relative told us, "Staff are kind."

During the inspection we noted some people's interests, preferences, and their hobbies. However, staff did not make references to these when they were engaging with people or trying to get people to engage with social activities.

We were told about how the service had advocated on behalf of two people who lived at the home, to ensure they received services from health professionals and social services. This included the service contacting their representatives and advocate to support these two people to receive the help which they needed.

There were times when staffing levels were low. As a result of this we could not be confident that at these times people received the time and support they may have needed. When we raised this issue of staffing levels with the registered manager they told us of some of the steps they had started to take to address this issue.

The staff we spoke with explained to us about how they promoted people's privacy and dignity. Staff said they knocked on people's doors and they spoke with people throughout supporting them with personal care. However, one member of staff indicated that sometimes they have had to leave a person while they were dressing them to support others or answer the door.

When we visited the home all people's confidential and sensitive information was kept securely. We observed staff accessing people's files and returning these records and locking the cabinet where these records were located.

People who we could communicate with told us about how they maintained their independence. One person said, "I've finished cleaning my room. You can come and talk to me now." Another person said, "I am going to my church lunch later. I go on my own. It's just across the road."

The staff we spoke with told us how they promoted people's independence. This was often related to supporting people to choose their own clothes and asking people what they wanted to do while they were at the home. A member of staff and the registered manager told us how they supported people to spend their money, budgeting and saving up for items that they wanted to buy.

We spoke with people's relatives who told us that they felt comfortable visiting the home whenever they wanted to see their relative. One person's relative told us, "You can drop in any time and it's always clean and warm." Another person's relative said, "I make a cup of tea when I go (to the home)."

Requires Improvement

Our findings

We visited Mulberry House in January 2016 and found they were providing Good responsive support to people who lived there. When we visited in February 2018 we found areas where improvements were required.

When we looked at a sample of four people's care assessments, care plans and reviews we considered if people had been involved in the planning of their care. In previous assessments when people first moved into the home there was some references to what people said, indicating they had been involved in planning their care. On one occasion a person had written on their care assessment. People had pictorial care plans and in some cases a member of staff had documented that these had been explained to the person. However, this was not always the case. Nor was it evidenced at people's reviews if they had been present at their review and contributed to their review of the care they had received.

People's care plans and assessments did make reference to people's interests and social needs. However this was limited information. For example one person's record stated they liked music and films but it did not state what types of films or particular films they enjoyed. Their care assessment also did not say what types of music or particular bands or musical artists they enjoyed listening to. People's assessments did not always fully explore their histories but they did indicate the family members who were important to them. People's ambitions and goals were considered but there was no evidence that action was taken, about how staff were trying to support these people to realise these goals and ambitions.

On the day we visited Mulberry House staff told us that they were trying out some new activities. One member of staff said, "So bear with us." The activity was trying to replicate going to the library but staff used TV magazines rather than books. We discovered by looking at people's records and visiting some people's rooms what their basic interests were. However, these interests were not explored at this activity. We asked one member of staff why they had not included these people's interests into this activity. They said, "We will do that next time, this is something new."

We spoke with the registered manager about this; it was unclear why there was a refocus on daily social activities and why the service had not got this right before. We were told that some people had had their day services stopped by the local authority, but a service ought to be still providing social stimulation and activities to people in the absence of this local authority service.

When we looked at people's reviews and their one to one conversations with staff these records identified outings and interests people wanted to explore. However, there was no evidence from these records, or from spending time with people and speaking with their relatives if these identified outings or interests had been realised. One person's review listed the things they wanted to do. At the following year review a similar list was given again. It was not evidenced that this person had been supported to realise these interests. There was no reference to this at their review.

There had been no recent planned trips and there were no future planned trips arranged. One member of staff said, "We were thinking about a coach tour sometime this year…We haven't arranged for the brochures to be sent to us yet." Another member of staff said, "I'm going to talk to [manager's name] about taking [person's name and person's name] to the zoo." However no plans had been made.

One person told us, "I'd rather go out with staff more, but they don't have time." A person's relative said, "[Name of person] gets bored sometimes, if [person] hasn't been out. But they don't' seem to go out in the winter with staff." A member of staff we spoke with said that people did not go out much in the winter.

During our visit one person independently went out to a local day centre arranged by social services, another person was supported to go out to the local shops, and some people went out for a ride to the pharmacy. However these were brief trips away from the home. We were told that people had one to one sessions with staff. We looked at the one to one books recording these sessions. These did not evidence trips out or social time spent together. Often it related to the person completing certain domestic tasks.

We observed the activities on the first and second day we were at the home. People did not engage with them. At one point people were asked what film they wanted to watch. Staff did not give examples or highlight films which were connected to people's interests. Eventually a vintage film was put on. Staff sat with people at this time but were completing paper work, they did not engage with people. Eventually a member of staff asked if people were actually watching the film. When they realised no one was it was turned off. Later some more active games were suggested which people interacted with for a short time. The staff we spoke with said they found people's motivation with activities challenging. Some staff said that they would benefit from some support from outside the home, in terms of finding activities that people would engage with.

The service was not supporting people to access information and meet communication needs of all the people who lived at the home. Two people used a form of sign language. We were told staff did not communicate with these people in this way, because they had not had the training. We noted that most staff had not had this training despite being at the home some time. Although we were told later, that this specialist training had been planned. There was no information around the service in formats which people could understand for example about how to make a complaint. The 'residents meetings' were written documents and these records did not show if the outcomes of these meetings were shared with people at the home. The activity cupboards in the living room had written labels on them saying what they contained. We asked a member of staff why these labels were not in a form that most people at the home could understand. They said, "No the labels are not for the residents. They don't all read. It's for staff so they know where to get things, for the activities." However, it had not been considered if people could access these cupboards independently.

During our visit we looked at the complaints received. The service had not had any complaints since the last inspection. We could see that there was a complaints process in place. However, when we spoke with staff some felt that suggestions of criticisms which were raised by staff were not handled in an open way. One member of staff said, "You get picked on." We raised this with the registered manager who said this was not

the case. However, from looking at staff meeting minutes and supervisions we could not see that staff were actively encouraged to make suggestions, to improve the service and challenge how things are done.

People did not have meaningful end of life plans in place. There was no evidence to suggest that staff had discussed with people and their relatives or representatives about their preferences, wishes, and spiritual needs at the end part of their lives. The registered manage said they had supported people or their representatives to have a paid funeral plan. However, other arrangements in relation to this part of people's lives had not been explored with individuals.

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

Inadequate

Our findings

The inspection in January 2016 found that Mulberry House was well led. At this inspection in February 2018 we found that the service was Inadequate.

There were multiple breaches of the Health and Social Care Act 2008 (Regulated Activities).

The registered manager was not present for most of the week on an on-going basis at the home. Although they worked a full week this was condensed into three days. The registered manager lived many miles away from the home. There was no process for management support in emergencies. In addition to this there was no clear accountable defined leadership of the home on the days they were not present. The deputy manager's post had been vacant for a long time and no short term or long term plan was in place. The care shift lacked leadership. None of the present staff wanted to work as seniors; the reasons for this had not been explored. We found that the service's contingency plan was insufficient to guide staff about what to do in certain potential emergencies that could occur at the home. One member of staff said they would not call the manager because they live so far away.

Concerns had been raised about the staffing levels of the home from multiple sources. The worked on staff rotas validated these concerns. We found that staff worked long shifts, supporting people in high energy situations, and at times there was a lack of staff available to support people and ensure they were always safe at the home. The skill mix of the care shift had not been considered when selecting staff to work on the shift. Concerns had been raised about the culture of the home. In terms of challenging or questioning decisions and practice.

We identified issues with the maintenance and up keep of the home. As a result of this we spoke with the administrative member of staff and quality monitoring member of staff. We were shown records which demonstrated that some of these issues had been raised with the provider (owner) of the service. In respect of the windows this had been raised in 2016 and the provider said they would replace the windows. No date was given no plan was made. They later said the windows would be replaced in February 2018, despite us inspecting this month no contact had been made by the provider, no plan was in place. We were told that this issue had been raised before but no action had taken place. Contact had been made with the provider about improving the garden for the people who lived at the home, but no response or action was given by the provider. Staff were not confident these improvements would happen. We later learnt that the provider had informed the home that any general maintenance requests had to be approved by them first. A concern was that this could delay repairs to the service.

The quality monitoring member of staff showed us a list in January of improvements they had identified as needing to happen. This did include the poor paintwork in people's rooms and the communal areas. However, looking at the maintenance records it was considered that in 2017 the repainting could wait until 2019. The lounge had been redecorated recently. The quality monitoring member of staff said that the provider asked them to obtain five to eight quotes to give to the provider to consider, for any potential work to be carried out. We concluded that the provider was unwilling to spend money to improve the service. It was inferred this was a historical issue. This questioned the provider's approach and how they valued the people living at the home.

We judged that despite staff attempts to secure improvements, the provider had consistently failed to respond to requests for financial investment. This lack of financial investment, to improve the quality of the environment and people's lives, demonstrated that the provider was unwilling to give sufficient priority to valuing people and their care. We found the home looked unkempt in parts. We were told that some members of staff had to put a lot of energy into getting basic maintenance issues addressed and resolved. Expectations were therefore low about what staff could expect from the provider. The fact that some people did not have curtains and blinds at some of their windows was not considered at issue. People had not been consulted with about this. The urgency of the fire doors not working was not identified. We often heard staff at all levels at the home say, "We try our best." There was an implication that the provider was not helping the service to do better.

There was a lack of planned events and activities taking place to meet people's social needs, interests, and hobbies. There were delays in arranging events. People were not given the opportunities to explore and realise their goals and ambitions. Staff struggled to motivate people and help them engage with activities. This had not been identified and explored by the registered manager and provider.

We found that there was some quality monitoring systems in place in relation to medication administration and medication audits. Although we did observe poor practice regarding one person's medicine administration. Also, the medication audit did not evidence what action was taken when an issue was identified. Daily records were checked. People maintained their health appointments. Staff practice in how they interacted and related to people was positive.

Alternatively we found that some audits were not effective. Some people's care records, assessments, and reviews were not up to date. They did not always evidence the new issues which people had faced and what action staff had done to address these issues. Some incidents and events had taken place which had not led to a review of need and re-consideration about how to best support certain individuals. Some people's reviews were not fully person centred and considered all aspects of their lives.

The competency of staff was not being robustly and routinely monitored to ensure they were effective and competent in their work. Staff's training was not checked to see if the training had been effective. Other ways of continuous learning at the home had not been considered.

We looked at the yearly provider audit and found this was not robust. The last audit had not identified the issues which we found. When they spoke with staff they did not check staffs understanding of key areas to their work. The maintenance and condition of the service was not subjectively considered in a transparent way. The level of activities and whether people's interests and ambitions were being fully explored and realised were not identified. The provider had not responded or checked regarding how the leadership of the service was working with a registered manager only present three days a week, no deputy manager and no senior staff leading the shift.

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

The registered manager and provider have a legal responsibility to notify us about certain events which affect people at the service, by law. We identified some events which the registered manager and provider had not informed us about which affected the people who lived at the home. One person had sustained a serious injury and a person had got lost and had not been able to return to the home independently. We were told later that the service had notified us of this event. However, our records did not confirm this. The registered manager had not checked that this had been sent correctly. Therefore we were not confident that the registered manager and provider were fully aware of all the events they must inform us about.

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

With the exception of health and social care professionals, there was no community involvement or attempts made to involve the wider community with the service. One person went to local authority arranged and funded day services and another person went out locally but there were no other attempts made to involve people into the community. This is not good practice. People were not being supported to be part of their community or to develop relationships with people. The home did not have a plan to address this issue. Relatives were asked to answer questionnaires and we were shown a recent collection of completed questionnaires. The registered manager did say that they listened to relatives and respond to issues which they raised.

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) (a) (ii)

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 people's social needs and preferences are met. Regulation 9 (1) and (2).

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 people are always treated with dignity and respect. Regulation 10 (1) and (2).

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 assessed all risks to people's safety or taken appropriate actions to mitigate these risks. Regulation 12 (1) and (2) (a) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance The provider had failed to have effective systems and processes in place to monitor and improve the safety of the service provided and to maintain securely an accurate, complete and contemporaneous record in respect of each service user. This also included the management of the service. Regulation 17 (1) and (2) (a) (b) (c) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 HSCA 2008 (RA) Regulations 2014: Fit and Proper persons.

	The provider had not ensured that there are always sufficient numbers of suitably qualified competent staff at the service. Regulation 19 (1) (a) and (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA 2008 (RA) Regulations 2014: Staffing The provider had not ensured that there are always sufficient numbers of suitably qualified competent staff at the service. Regulation 18 (1) and (2) (a).