Buckland Care Limited

Mulberry House

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Mulberry House is a residential care home providing personal care for up to 42 people. At the time of the inspection there were 25 people living there. Five of those people were receiving intermediate care which meant they were planning to be discharged home following a short stay. The home is spacious, and purpose built with a large garden, accommodating people across two floors accessed by a lift, each of which has separate adapted facilities.

People's experience of using this service and what we found
Due to poor management of risk, people were at risk of harm. We found multiple examples of poor care and inadequate monitoring of risk in relation to malnutrition, dehydration, incontinence, falls, poor manual handling, infection control, choking and pressure care.

People and relatives expressed concern over the lack of stable management and staff team, a lack of communication and of not being listened to. One relative said, "We are there all the time, but [staff] rarely tell us things. My father tells us things."

People were not adequately supported to eat and drink to ensure they were not at risk of choking. People did not receive appropriate diets or and were not supported to maintain good hydration and nutrition.

There was poor falls management with a lack of risk assessments or detail about how staff should minimise the risk of falls. Incidents and accidents were not always recorded, or appropriate actions taken to minimise the risk or identify and learn from trends and patterns.

People were not always able to access working call bells and those people who could not use a call bell due to their mental capacity had not been assessed or systems put in place to regularly check their wellbeing or to ensure their needs were being met.

There was poor pressure area care as there were no systems in place to ensure regular monitoring, recording or ensure actions were taken to minimise pressure skin damage. There was poor continence management resulting in soiled bedding and continence aids which further exacerbated people's skin integrity.

People were at risk of poor moving and handling and the use of inappropriate equipment which put them at risk of harm.

People did not always have up to date care plans in place, so they were at risk of not having their care and support needs met by staff. Staff were not always knowledgeable about peoples' needs or able to give person centred care because poor leadership did not enable them to have up to date information. Systems were not effective at sharing important information and was exacerbated by the high use of agency staff.

People were not protected from the risk of cross infection due to poor infection prevention and control practices relating to sharing of equipment, poor continence management and housekeeping.

People did not always receive their medicines as prescribed, including topical preparations, which put them at risk of ill health.

Staff leadership and deployment of tasks was poor and staff did not always know what they should be doing. However, people and relatives generally said that when people were supported staff were kind and caring. Comments included, "They treat [person's name] with respect and kindness, every time I speak to staff, they speak of them. I have seen other residents being treated properly" and "Whenever I see [staff] around [person's name], they are very kind and loving. The staff speak to you when you go through the building."

Staff did not always have the necessary skills, training and supervision to support people effectively. Staff training and induction was not effectively managed. Supervisions did not routinely take place and staff competency checks were slow to be completed.

People were not always safeguarded from abuse because staff did not always identify safeguarding issues or record or follow safeguarding escalation processes to keep people safe.

There was poor oversight of the service and a lack of consistent and effective managers in post who had the time to make improvements. There was a lack of effective monitoring and systems in place to monitor the safety and quality of care.

People did not always have access to healthcare professionals in a timely way.

Staff were not always recruited in a safe way which put people at risk of poor care by staff who may not be suitable to support them effectively.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 16 December 2019). The service had a targeted inspection (published 15 September 2020) which was not rated. The service has deteriorated to inadequate. This is based on the findings at this inspection.

Why we inspected
We received concerns from the local authority identified during the ongoing provider quality support meetings in October and November 2021. These concerns were in relation to the lack of up to date care plans, training, particularly the lack of medicines training and competency and training in the electronic care planning system (PCS), high use of agency staff, management pressures resulting in a lack of improvement and governance oversight. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led. We reviewed the information we held about the service. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this report.

Enforcement
We have identified eight breaches in relation to: the need for consent; safe care and treatment of people; person centred care; safeguarding people from abuse; meeting nutritional and hydration needs; staffing; premises and equipment; management oversight of the service, and a lack of good governance. We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will continue to have updates and meet with the local authority through the whole home safeguarding process. We gave formal feedback to the provider regarding the urgent actions required following the first and second day of our inspection. We will request an action plan for the provider to complete so they understand what they will need to do to improve the standards of quality and safety. We will return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements. If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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 well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Mulberry House

Detailed findings

Background to this inspection

The 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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and one pharmacy inspector. An Expert by Experience made telephone calls to relatives to seek their views as part of the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The home did not have a manager registered with the Care Quality Commission at the time of the inspection as the previous registered manager had very recently left the service. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced on the first visit and announced on the second visit.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and from health and social care professionals who worked with the service. The

provider was not asked to complete a provider information return prior to this 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 took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke or spent time with 15 people who used the service. Many of the people were unable to directly tell us their experiences due to living with dementia. We received feedback from nine relatives about their experiences of the service. We spoke with the provider, nominated individual, area manager, manager, new deputy manager, ten care staff, two domestics, laundry person, new cook and agency cook and the activities co-ordinator. We reviewed a range of records which included three staff recruitment, supervision and training files, multiple people's care records and medication records, daily care notes and falls records. A variety of records relating to the management of the service, including audits, quality monitoring and policies and procedures were looked at.

Inadequate

Is the service safe?

Our findings

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

At the last rated inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our inspection in September 2019 we were concerned about the operation of systems for the assessment and management of risks. At that time, we found where care plans had identified risks there was not always an associated care plan to guide staff how to mitigate these risks. We found daily notes were added to the electronic care planning system (PCS) without care plans and information on risks being added so it was not easy to identify risks to people or how they were being managed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In the unrated targeted inspection in July 2020 there had been improvement in risk management.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17 relating to good governance.

● People and relatives were not always confident the service was safe. One person said staff did not always know how to support them with their mobility and they had been pulled up from the bed by their arms. A relative told us, "I would have said it was safe but now I am not sure. There are a lot of agency staff, but they don't create a bond with the residents, they are here today and gone tomorrow. Some of the agency staff are a bit abrupt with the residents. The longer [person's name] stays there, the more unsafe she is, because she isn't walking any longer." Another relative said, "There have been so many little things [concerns], [person's name] ended up with pneumonia and in hospital. [Person's name] asked for help, and nobody came back to him." Two staff members told us people were not safe, "Not at all." The manager told us, "I come to work sweating, I'm so worried about people."
● Risks were not accurately assessed, identified and managed to mitigate the risk. Although the electronic care planning system showed people had been identified as being at high or very high risk, there were no corresponding care plans showing staff what actions they needed to take. This was widespread throughout the service. The manager confirmed these records were not in place.
● Care plans were not always up to date so staff could not use those to access current information and agency staff had no information at all as they could not access the electronic care planning system. After the first day of inspection, we asked that summaries of peoples' needs and risks were provided to all staff but on the second day of inspection, despite there being six agency staff on shift who did not know the service, these were not in place until we asked them to be given to staff. Agency staff told us they knew nothing about the service or peoples' needs.
● People were at risk of harm because they could not always access a working call bell. Two people had intermittently working call bells. One person said, "No-one ever comes to help me." They had recently fallen

in their bathroom and had been heard shouting. Another person with an intermittently working call bell was heard shouting for assistance on the second day of our inspection so we alerted staff.

● There were no regular checks for people who were unable to use a call bell due to their mental capacity. The manager was unable to tell us who these people were and confirmed there were no records of any regular checks or systems to inform staff who required regular checks, which put people at risk of harm or not having their needs met.

● Pressure care management was poor. Staff and the manager were unable to tell us who was at risk of pressure damage. There were no risk assessments to identify people who were at greatest risk or who required regular re-positioning to prevent skin breakdown. One staff member told us they were very worried about a person's sore skin. Their daily records on the second day of inspection said, 'Red areas must be washed, fully dried and creamed' with previous daily record entries in December describing their red, sore, painful and raw skin. There were no records of regular checks and management of their skin. There were no body maps or information about their current skin condition. This meant they were at risk of further damage and lack of treatment to maintain their skin integrity.

● Another person's care plan stated their 'sacrum is at risk- check at least three times a day'. There were no records of regular checks or re-positioning, but a daily record entry stated, 'noticed their bottom very red, no cream in their room'. Staff said they did not read back through any daily records and relied on verbal handovers.

● Some people slept on air mattresses to minimise the risk of skin damage. There were no checks in place to ensure this equipment was working correctly. No records were kept ensuring these specialist mattresses were at the correct setting in line with the person's latest weight. This meant people may be at risk through lack of equipment checks.

● Continence management was poor. On the first day of our inspection the laundry person told us there had been 15 completely wet urine-soaked beds that morning. An agency staff member told us all four of the people they had been to support on the second day of the inspection that morning had been wet in bed with urine. Staff had no information about who required regular assistance with maintaining independent continence. There were no records of regular checks and support with continence. Daily records for people showed numerous entries stating that peoples' continence aids were wet when staff went to support them.

● An agency staff member told us they were concerned that people were not using the correct continence aids. There were no records of which aids people used and staff were using various types that were all together on the laundry trolley or there were various types stored in peoples' rooms. This further exacerbated skin integrity.

● Staff did not have information about peoples' diets. One person was on a puree diet due to their risk of choking and repeated chest infections. Their care plan stated they often moved around the home taking food from other people. An incident had occurred in December 2021 where they had taken a sandwich from a trolley. Their relative told us they had been informed and were very concerned. They told us, "I am concerned about the safeguarding issue about pureed food and the agency staff who don't know [people's names]."

● People were at risk of falls because although their care plan had identified their high or very high risk of falls there was no care plan informing staff about how to mitigate the risk. An agency staff member said one person's mobility was decreasing but nothing had been done. They thought the person required a hoist, but staff were using a frame. This person had recently fallen in their bathroom unwitnessed. The manager told us they had stopped one person falling three times on the first day of inspection. They had no falls risk assessment or care plan and were in the lounge unattended.

● One person had sustained a serious injury whilst outside unsupervised. Their care plan said they were unsteady, disorientated and used a stick and for staff to ensure they had their call pendant. There was no information about how this was monitored, and the person had fallen unsupervised outside without having their call pendant.

● The lounge was left unsupervised most of the first day of our inspection with six people, some identified as high risk of falls. One person's care plan said not to leave them alone in their wheelchair due to falls. Staff told us two other people were at risk of falls, but no staff were allocated to the lounge. The provider told us after the inspection the activity co-ordinator supervised the lounge, but the activity co-ordinator was not in the lounge on either day of our inspection.
● Risks associated with mobility support were poorly managed. Care plans were not up to date and there was no information about what peoples' current needs and equipment were. We observed two staff trying to assist a person using equipment that would have resulted in a fall. Other staff told us they usually used electric equipment, but this was not documented. Another person was seen using the wrong hoist sling that put the person at risk of falling out of the hoist.
● Some people living at the home had bed rails in place to prevent them falling out of bed. The manager and staff were unaware of which people had bedrails, there were no risk assessments to assess whether they were safe to use, and they were not checked regularly to ensure they were being used correctly.
● People did not always have appropriate access to health professionals. On the second day of our inspection, one person was unresponsive when we passed their room. Two staff were attempting to take their clinical observations but said they had not been trained to do this. The manager said this event had occurred before but there was no care plan about how staff were to respond. We asked that an ambulance was called. Another person who had sustained a serious injury during a fall was found in bed bleeding profusely. They were on blood thinning medicines. The area manager had called a community nurse who did not arrive for four hours. The person was left largely unattended in the library until the community nurse arrived and confirmed to us that they had called an ambulance.

The lack of risk assessments and safety monitoring systems in place, put people at risk of harm. People were put at risk of receiving support from people that were not suitable to support them. These are breaches of regulation 12 (Safe treatment and care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We took steps which required the provider to take actions within 24 hours to make people safe, including reviews of individuals. They responded and said they had taken action. On the second day of our inspection, we checked on these actions. However, summaries of each individual had not been given to staff to ensure they knew peoples' needs and risks on the second day, so we ensured this was done.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from abuse or neglect despite the majority of the staff having completed online safeguarding training in 2021. The service had been in a whole home safeguarding process from September 2019 relating to the above concerns almost continuously until July 2020. The service showed some improvement and was then part of the provider quality support (PQSP) process until this inspection in December 2021 when it again went into a whole home safeguarding process due to the findings of this inspection.
● The manager told us they thought safeguarding incidents were not always recorded or reported. They felt the records were not up to date and that actions were not followed through where there was a safeguarding incident reported. For example, there was no safeguarding alert made relating to the person who had been able to take a sandwich from a communal food trolley when they were known to be at risk of choking. There was already a safeguarding alert for this person recently in relation to them eating a banana in similar circumstances. We made a safeguarding alert to ensure they were safe, and one to one monitoring was put immediately in place.
● The person who had suffered a serious injury from a fall outside had had no accident form, poor wound monitoring and a lack of wound care information. There was no care plan or monitoring records despite

comments in the daily records stating a deterioration and that 'the hand looks nasty and staff need to keep an eye on it.'
● Another person's daily notes said they had had an unwitnessed fall in their bathroom due to slipping on a discarded clinical waste bag. There was no accident form, risk assessment or follow up to minimise future risk. A health professional told us a staff member had told them of an incident a month ago relating to the way an agency worker had treated a person. The manager was aware of inappropriate behaviour regarding that worker and had informed the agency, but a safeguarding alert had not been made by staff.

Poor safeguarding systems, processes and practices at the service, put people were placed at risk of harm. This is a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, we reported five safeguarding incidents to the local authority safeguarding team and visiting health professionals raised a further six safeguarding alerts. This was because we were not confident these had been recognised by the provider.

Preventing and controlling infection
● At this inspection we found some failings with regards to infection prevention and control practices which meant people were not fully protected from infection control risks. There was no oversight of housekeeping and laundry tasks.
● On the first day of inspection we saw a staff member taking a moving and handling sling from one person to use immediately after for another person. People did not have named slings and staff said they used whatever was available. There was no cleaning schedule in place for the slings. This left people at risk of cross infection from shared slings that were not clean.
● A staff member showed us photographs they had taken of large piles of soiled linen bags that had built up overnight. This was because night staff had not known to continue with washing overnight. We observed a large pile of clinical waste bags left in a communal bathroom. This put people at risk of coming into contact with clinical waste. We noted that a person had slipped and fallen on a clinical waste bag left on their bathroom floor.
● On the second day of inspection we saw an agency staff member doing the medicine round. They did not wash their hands or use hand sanitiser between administering medicines to different people. The manager said there was no infection control lead to oversee staff practice and implement infection control and prevention guidelines.
● There were three domestics employed. Two domestics told us there were sometimes only one domestic on shift which meant they could not clean the whole premises. Staff told us beds were often not made or sheets changed unless they were soiled and that window-sills were often dirty. A laundry checklist in November 2021 had raised the issue of staff shortages but no action had been taken.
● Staff had to take commode pans upstairs to the sluice to wash. Domestics said this meant staff usually rinsed commode pans in peoples' rooms but there were no cleaning fluids to wash them properly.
● There was no evidence of deep cleaning of rooms or high touch points to ensure risk of cross infection was minimised. There was no COVID-19/pandemic specific cleaning schedule or equipment cleaning checks despite communal manual handling equipment being used.
● Six of the 20 employed staff had no infection control training. A further four staff had not updated their training for over 12 months.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

The lack of robust infection control and prevention practice put people at risk of cross infection. This is a breach of regulation 15 (Premises) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

● During a targeted inspection in January 2021 we were assured infection prevention and control measures were in place at the time in relation to the COVID-19 pandemic. At this inspection we found that in relation to the COVID-19 pandemic, processes were generally in place to minimise the risk of cross infection from COVID-19.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service in relation to the COVID-19 pandemic.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Using medicines safely
● Improvements were needed to the way people's medicines were managed. People did not always receive their medicines in the way prescribed for them. One relative said, "Staff have phoned to ask what time [person's name]'s medication happens [as they did not know]. Their medications are being late."
● There were insufficient staff trained and assessed as competent to administer medicines in the home. Staff told us this shortfall was made up with agency staff who may not be familiar with residents, their medicines, or the electronic system in use, meaning there was an increased risk of medicines errors or incorrect recording.
● There were problems with medicine supplies, and four people's charts showed one or more missed doses due to medicines being recorded as out of stock or waiting for supplies. In some cases, receipt of medicines had been recorded previously which meant that sufficient supplies should have been available. Therefore, it was not possible to tell if doses were missed due to lack of supplies, or due to incorrect recording on the electronic system.
● There were gaps in three people's records where there was no record of doses being given, or any reason recorded for the missed dose. This showed people did not always receive their medicines as prescribed for them.
● There were separate recording sheets in use for creams and external preparations. However the records we checked were poorly completed by staff, and it was not possible to be sure that these preparations were applied when needed or as prescribed to be used for people

People did not always receive their medicines as they were prescribed which put them at risk of ill health. This demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Medicines were stored securely, and temperatures were monitored to make sure they were stored correctly.
● People could look after their own medicines if it was assessed as safe for them to do this.
● When medicines were prescribed 'when required' we saw some person-centred guidance that was available to guide staff when it would be appropriate to give a dose. We were told that this would be added to the electronic medicines system to make it easier for staff to be aware of, particularly if agency staff were administering medicines.
● Medicine audits had been completed recently, and we saw that some areas for improvement had been

identified, including issues with supplies. We were shown new systems that were being introduced to try to overcome these issues.

Staffing and recruitment

● Staff were not always recruited safely. Checks were made on staff members suitability, such as employment history, references and criminal convictions. However, one new staff member was asked to do a task that their reference clearly stated may not be appropriate without further investigation and they had no risk assessment for a significant medical condition. Another senior post had been recruited into but there was only one reference that had not been examined to ensure its suitability or further information gathered to ensure the appointment was appropriate.

● There had been a high turnover of staff at the service, and consequently there had been difficulties with recruitment. A relative told us, "I feel there is inconsistency and lack of care about the place. They are just so short staffed and new staff don't know the needs of people in there."

● Due to recruitment problems there had been a reliance on agency staff. However, agency staff working at the home were not given the personalised information required to inform them about individual people's care, preferences and social needs. This was essential as many people were living with dementia and could not always explain what support they needed and how they wanted this to be provided.

● Staff were not deployed effectively, which put people at risk. On several occasions throughout the inspection, there was an absence of visible staff in communal areas.

The failure to ensure the effective deployment of suitably competent and experienced staff is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● The inspection history for the service shows there had been not been effective learning from previous issues, for example in relation to staff recruitment. At the last inspection in July 2020, two staff did not have enough information in their one reference to be able to make an informed judgement on their suitability. The manager then told us there was now a recruitment tracker to audit records. However, we found this was not being used and there were issues with robust recruitment.

● In November 2020 a quality support meeting with the local authority had raised the issue of care plans not being up to date, with support given to the home in October 2020. This had still not been completed to ensure staff, especially with the high use of agency staff, had the information they needed to meet peoples' current needs.

● Staff had brought up issues with the local authority in relation to training needs but no further training had been completed. For example, there were only three staff trained in medicines administration, no further staff had been trained or had their competencies assessed. The manager said there had not been time.

● There had been no analysis undertaken to look at trends or patterns of falls. The manager said not all falls were being reported. Because of this it made it difficult for the manager to learn lessons and put improvements in place if they were not reported and documented. We saw that 10 falls had been recorded in the daily notes in December 2021, but none had been recorded on accident forms. The manager knew about some falls but said no actions had been taken and there had been no reassessment of peoples' needs. This included the person who had slipped on a clinical waste bag and another person who had sustained a serious injury when falling unsupervised outside.

The lack of monitoring and learning from incidents at the service, put people at risk of harm. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we contacted health and social care professionals about the concerns we had found in relation to people's safe care and treatment. The local authority planned to carry out reviews of care for the eleven people relating to the safeguarding alerts. The local authority ensured that occupational therapists, community nurses and the quality improvement team visited the service immediately to ensure people were receiving safe and appropriate care and to offer support and training.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience;

- Staff were not always knowledgeable about people's needs as poor leadership, including leadership of each shift 'on the floor' and lack of up to date and person centred information did not equip staff with the information they needed to meet peoples' needs. The manager said, "The care plans need more depth but there is no-one to do it, we have some staff working on it at home." Relatives comments included, "The [permanent] staff are definitely skilled, some of the agency are and the other agency staff who have only been there a week, are definitely not skilled."
- The six agency staff told us on the second day of inspection they had not had a tour of the home and were asking us where rooms were to be able to answer call bells. They had no information about peoples' needs and risks and had not been allocated to support named people. One agency staff member told us they had called their agency as they did not feel the home was safe.
- There was a lack of senior staff to lead the staff team 'on the floor'. The manager said this was an issue as there was no time to train staff up. A care worker had been asked to act as senior on the second day of our inspection but they told us they were not comfortable as they had only been at the home for a few months and had had a meeting with the manager to say they did not want to be a senior. They later were allocated to activities, which left no leadership of the six agency staff.
- Staff were not effectively trained or supervised to ensure people were always well supported. Some staff had not had a supervision since employment with the last recorded supervisions being in October 2021.
- New staff in post did not have an effective induction. They were given a day's orientation and then shadowed a member of staff. Their care practice was not monitored, and competency checks not carried out. Therefore, management were unsure if they were supporting people correctly. One new staff member was asked by the area manager to administer medicines on the first day of inspection, but the new staff member had not had medicines training and required a risk assessment due to information in their recruitment file. The second care worker had not had their competency for medicines administration completed. Neither were confident to carry out medicines administration, we intervened to ensure competent staff were sourced.
- Where they had received training, staff did not always apply this to their practice, for example in relation to moving and handling, infection control, falls management and pressure area care. Eight staff had not had training in basic life support including choking and six staff had not had training in dementia care. Staff were not trained in wound care, but a senior staff member had dressed a serious wound for one person. The manager said the dressing could have been done better.
- There were no records of which staff had been trained in the new electronic system (PCS). Agency staff had no access to the system and could not complete daily records or access care plans. One senior staff member

said they were not confident using the system.

Due to the lack of knowledge and skills, training and supervision of staff at the service, people were put at risk of harm. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities).

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

At our inspection in September 2019 we were concerned about the failure to ensure care plans had been compiled with each person to include their preferences regarding their needs and choices about their care. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9 relating to person centred care.

● Handovers were not always effective at ensuring important information was passed on. These were verbal and staff were unable to tell us about peoples' needs, risk and mental capacity. Important information was 'lost' within daily records and described people as having pain, requiring a GP, having sore skin or a fall with no records that these issues had been followed up or acted upon.
● There were two examples during our inspection where people had not received referral to health professionals in a timely way and we had to ensure this happened.
● Staff did not know how peoples' usual health conditions presented and therefore were unable to ascertain if they were well. Daily notes contained many examples of staff suggesting referral to a GP for medicines or to assess skin damage but there were no records to show if these had been followed up.
● Due to the lack of consistent staff who had knowledge about peoples' needs, staff were unable to deliver person centred care. Peoples' comments included, "The staff don't seem to know about me", "I'm asked for my lunch meal choice but they rarely bring what I've chosen" and "I don't see anyone all day except when the staff come in the morning and to bring my lunch." Relatives told us, "There has been such a change of staff recently. [Person's name] does not like marmalade on his toast but was being given this every day. We now provide apples in his room, we shouldn't have to keep on asking. There is such a change of staff", "[Person's name] gets frustrated about not getting up early in the morning, everyone is busy" and "There are more agency staff than normal staff." One staff member said, "[Person's name] stays in bed until 11 most days as they need encouragement to get up and staff don't have time."
● One person told us, "We had one agency staff member who just stood in the corner and I had to tell him what to do." Two people said they were asked to choose their meals each day but often did not get what they had chosen. The laundry person was going around peoples' rooms checking that peoples' laundry was theirs as peoples' clothes were seen to be in other peoples' rooms.
● There was information about peoples' preferences for what food they liked, when they liked to get up and go to bed. During the inspection at least four people were having breakfast after 10.30. They were living with dementia so unable to tell us their preferences but were then offered lunch at 12.30. The laundry person told us sometimes people were in bed at 12.30 and one day a person had breakfast whilst others had roast dinner. One staff member told us that [person's name] had been supported to get out of bed at 6.30am and 'they were not happy about it'. One person said, "I get a quick wash as staff don't have time and sometimes I have to clean the bathroom myself." This was the person who had slipped on a clinical waste bag in their bathroom.

● One staff member told us, "It depends which are staff are on duty as to how we mobilise [person's name]. An agency staff member told us one person had a painful shoulder and staff were using a standaid and belt that was not suitable. They said the person's needs had deteriorated but 'no-one had done anything about it'. One person living with dementia moved around the home all day unsupervised with no engagement. This was the person known to sleep in another person's room during the day, as noted in their care plan and who was at risk of choking and was known to take others food. We ensured this person received one to one support after the first day of inspection to keep them occupied and safe.

The lack of person centred care is a continued breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities).

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our inspection in September 2019 we were concerned that the service had not acted in accordance with legislation to protect peoples' rights with regards to The Mental Capacity Act 2005. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11 relating to need for consent.

● On our first day of inspection, there was poor oversight of DoLS applications so it was not fully known who had an application submitted, what the outcome was of an application (if there was an outcome) or whether there were any conditions if an application had been granted.
● Some people were being restricted in their movements and this had not always been considered or included in DoLS applications. For example, those people with bedrails or pressure mats in place (which raise an alarm when the person moves). There were no risk assessments for bed rails to ensure they were used safely or evidence of any best interest decision making.
● The manager was not able to tell us which people had mental capacity or who could use a call bell. There were no mental capacity assessments and staff had no knowledge of who was able to make decisions or how their mental capacity affected them day to day.
● Care plans were confusing. One person's care plan stated they lived with dementia with minimal communication but also stated they had consented to having their photograph taken and sharing information with healthcare providers. Therefore, staff had no clear information about peoples' mental capacity. Seven staff had not had training in the Mental Capacity Act or Deprivation of Liberty (DoLS).

The lack of knowledge and understanding about peoples' mental capacity to ensure support was delivered in a way that met their best interests was a breach of regulation 11 (Need for consent) of the Health and

Social Care Act 2008 (Regulated Activities). This was a repeated breach from our inspection in September 2019.

Supporting people to eat and drink enough to maintain a balanced diet

● People who were able to said the food had been variable as there had been some changes in cooks. People all said they had not been asked by the cooks what they would like to see on the menu. One person said, "I love onions and cabbage, but I haven't had it for a long time. Sometimes the meals are a surprise or a shock." Relatives said, "It is not brilliant, good and bad, sometimes it is inappropriate for the residents, I saw raw chips and raw scampi, I complained about this about 3-4 weeks ago." Another relative said, "[Person's name] would usually eat most things, but he says it is a bit 'gloopy', there is now a new chef, but he is losing weight."

● People were at risk of malnutrition and dehydration. The manager was unable to tell us who required closer monitoring of their food and fluid intake. Food and fluid charts were poorly completed, showing minimal food and fluid consumption, and a poor diet. Two people with low weights under 50kg had had no food recorded for three days on the second day of inspection. There was no oversight, which meant concerns were not escalated, or action taken to promote nutrition and hydration.

● There was no oversight of people eating their meals in their own rooms, or regular support from staff to encourage them to eat. This increased their risk of malnutrition. On the second day of our inspection, one person came out of their room at 2.30pm to ask where their lunch was. People did not have drinks next to them in their rooms or in the communal areas. This was also raised by a visiting health professional after our inspection.

● On the second day of inspection there was a new cook. They had had no induction and had not been told about peoples' dietary requirements. They told us they were from a catering background. They did not know what dietary levels meant (International Dysphagia Diet Standardisation Initiative) or what peoples' preferences were. As a result, everyone received a normal diet including those with diabetes and those at risk of choking. These meals were delivered by agency staff who also had no knowledge of peoples' dietary needs or risks. We asked that this be addressed with urgency.

● People with diabetes were at risk because there was no information in care plans about the support they needed to remain well and safe. They were eating foods which placed them at risk of harm because of a lack of control of blood sugars.

The failure to meet people's nutritional and hydration needs is a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Mulberry House is an adapted period building with large extensions creating wings over two floors. The premises are large and spacious enabling people move around the home easily with access to a central lift. The décor was fresh and had been updated to promote a comfortable and relaxing environment.

● A large atrium known as The Aviary with a conservatory at one end was used for communal activities, as well as the dining room, and as a television lounge. There was a comfortable library and a further room used mainly for visitors near the office.

● People were able to engage with books, newspapers or magazines. We saw people who were able to access these areas engaging with each other and staff.

● The building is surrounded by large grounds which looked well maintained.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to assess and monitor the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17. This is a continued breach of this regulation since September 2019.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems and processes to monitor and check the quality of care were not established and did not operate effectively to ensure compliance with the regulations. There was a failure to act upon feedback from previous inspections to become compliant with the regulations. As a result, people were exposed to the continued risk of harm and poor care.
- Mulberry House was inspected in September 2019 and July 2020. On both inspections concerns were raised about the level of provider oversight and the quality of systems of governance. In July 2020 the provider had no oversight of the quality of staff inductions and there continues to be limited reporting of area manager visits. During this inspection, we saw a Care Home Provider Report and Service Improvement Plan for November 2021. This stated, 'More work needs to be done on clinical risk to the resident within the care plans and ongoing monitoring by staff'. However, we found serious concerns relating to risk management in relation to falls, skin care management, lack of risk assessments and actions for staff to follow to keep service users safe. There was no provider oversight to ensure the area managers were operating effectively to ensure issues were addressed.
- During our inspection, the manager and two area managers were present, but they had not identified the issues we found or addressed the lack of improvement or leadership issues. The Service Improvement Plan (SIP) November 2021 stated, 'There needs to be monthly clinical governance meetings to discuss residents' conditions and risks and to action the plan for support'. This had not happened. The SIP also stated, 'Audits need to be completed to demonstrate oversight- with actions required added to the SIP'. This had not been done and the last falls audit for example, was August 2021. Staff supervisions and appraisals were noted to require a clear timetable for completion. This had not been done. The manager and area manager said they were aware that there was no-one to make improvements as the manager said they did not have time. The area manager had been supporting Mulberry House for some weeks but had failed to identify any of the concerns that we highlighted. Both managers left employment after this inspection. The provider had failed to ensure the staff members chosen to stabilise and manage the service were able and making

improvements. This meant there was no review of the systems and process to monitor standards of care and ensure compliance with the regulations to ensure they were effective.

● There were no effective systems or processes in place to ensure the records about peoples' needs and risks reflected their current care needs. This was particularly important as many shifts included agency and new staff. Records were inaccessible, inaccurate, contradictory and could potentially put people at risk of harm of practice which was no longer appropriate and unsafe. We had to ask for information about peoples' needs and risks to be summarised and given to staff immediately to keep them safe.

● There was a failure to ensure effective monitoring of the day to day care provided at the service. Leadership and oversight of shifts was poor. Some shifts had no senior staff on duty or permanent staff leaving agency staff to give what support they could with no guidance. This meant people were at risk of harm as staff did not know what peoples' needs and risks were.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Staff told us they felt people were not safe, care was not being provided properly, changes in need were not identified and acted upon and that staff were not always completing tasks such as laundry and waste management at night. Staff said they had told the manager, but they didn't have time to address issues. One staff member said, "Staff just do what they want and go home."

● Relatives views were mixed. They told us they were concerned about the staff changes within the home and that staff did not always know what to do, but overall they felt able to make complaints that would be dealt with. One relative said, "we shouldn't have to keep on asking. There is such a change of staff." Another relative said, "Any concerns we speak to the manager, she is open and lovely."

● The manager and area manager told us during the inspection there were issues with lack of provider support and assistance to make improvements, but no action had been taken. However, they had not informed us sooner that there were concerns about the care provision.

Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● There was a failure of systems to ensure people received timely personal care and were treated in a respectful and dignified manner. A lack of oversight for the experience of people meant shortcomings were not identified. As a result, people were not treated with dignity and respect in a way that ensured their safety, privacy and supported their autonomy and independence. One relative said they had had to ask for adequate warm bedclothes and another relative said their loved one had sat in the lounge with a person who was half naked. On return from hospital we noted one person took an unsupervised shower with their arm heavily bandaged and walked back to their room in a small towel leaving a wet trail on the corridor floor. Staff had not been to check them on their return and staff we told due to noticing the wet floor said they did not know the person had returned.

● There were inadequate systems to regular monitor staff skills and training. For example, there was not a system to monitor staff inductions to ensure staff were made aware of relevant policies, as well as ensuring they had access to training suitable to their role. Staff did not routinely receive supervision or competency checks to ensure their practice was safe and to support them to meet people's needs. There were no records to show if staff were competent with the electronic care planning system (PCS) or had access.

● The current staffing arrangements at the home were unclear as rotas and training records were not kept up to date. Despite many people living with dementia, staff training in dementia awareness was not prioritised. This meant people were at risk of inappropriate care causing unnecessary distress, which put staff and other people at potential risk of harm.

● Quality assurance processes failed to identify action had not been taken to prevent the risk of dehydration with poor fluid intake. Neither had these processes addressed the risk of people becoming malnourished

and dehydrated. There were no systems or processes in place to ensure all people received regular and person-centred support with personal care and continence management to ensure they were clean, their skin was undamaged, and their dignity respected.

● The medicines audit system was not effective to ensure that people received the medicines and topical preparations that they were prescribed.

● In the previous two years, the local authority quality assurance and improvement team had supported the service on several occasions. This was to improve the management of the service and put systems in place to monitor and improve the quality of service. The manager had repeatedly commented that they were required to work 'on the floor' and this put pressure on making improvements. We saw the lack of leadership 'on the floor' during the inspection and the manager was not available to support staff, including the six agency staff and new cook. The lack of adequate monitoring of the service by the provider meant management systems were not being used effectively to sustain good quality care and ensure peoples' needs were met safely.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● One person told us, "There's something wrong at the moment." People described how there had been a lot of changes since the previous registered manager had resigned. They said they were not informed about changes or introduced to new managers. They said, "No communication at all, we don't get told anything at all." This meant people were left feeling unvalued and not treated as equals with opinions and views that counted despite them living at the home longer than many of the staff who worked there.

● There were no systems or processes in place to ensure all people had input in devising their care plans which would have made them more person centred and shown their consent to the contents of the plans ensuring they reflected their needs and preferences. People and relatives told us they had not seen the care plans.

● There were no residents or relatives' meetings or regular written communication with people and their families.

● There were no systems or processes in place to ensure all people's care was reviewed at least monthly or sooner, if needed, and where appropriate their families involved in this action. There was no audit of care plan reviews so we could not see when these were done.

Poor governance placed people at risk of harm. This is a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA RA Regulations 2014 Person-centred care There was a lack of person centred care