PureCare Care Homes Limited

Mulberry House

Inspection report

159 Barnsole Road
Gillingham
Kent
ME7 4JH

Tel: 01634280703

Date of inspection visit:
14 March 2018

Date of publication:
23 May 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 14 March 2018 and was announced.

This service provides personal care and support to ten adults living in 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. This supported living service meets the needs of people with mental health care needs. People use the service as a stepping stone from residential care to independent living in the community, they were mainly independent and did not require staff support all of the time. The service is run from an office on site. There were ten people using the service at the time of our inspection.

A registered manager was employed at the service and they were present during the inspection. 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.

We observed safe care. Staff had received training about protecting people from abuse and showed a good understanding of what their roles and responsibilities were in preventing abuse.

The registered manager had experience of managing mental health services. The registered manager spent time each week delivering the service alongside their colleagues. This meant that the registered manager had an in depth knowledge of how the service was running and got to know people and staff very well.

The registered manager involved people in planning their care by assessing their needs based on a person centred approach. We observed and people described a service that was welcoming and friendly. Staff provided friendly compassionate care and support. People were encouraged to get involved in how their care was planned and delivered. All of the people had the support of a community psychiatric nurse (CPN). People clearly had control over their lives when they were well. People could involve relatives or others who were important to them when they chose the care they wanted.

The person centred care plans developed to assist staff to meet people's needs told people's life story, recorded who the important relatives and friends were in people's lives and explained what lifestyle choices people had made. Care planning told staff what people could do independently, what skills people wanted to develop and what staff needed to help people to do.

The registered manager and staff followed the Mental Capacity Act 2005 (MCA). The provider understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA). Staff received training about this.

Staff assessed and treated people as individuals so that they understood how they planned people's care to maintain their safety, health and wellbeing and choices. Risks were assessed within the service, both to individual people and for the wider risk from the environment people lived in. Actions to minimise risks were recorded. Incidents and accidents were recorded and checked by the registered manager to see what steps could be taken to prevent these happening again. Staff understood the steps they should take to minimise risks when they were identified. The provider's health and safety policies and management plans were implemented by staff to protect people from harm.

The registered manager and the provider had demonstrated a desire to improve the quality of the service for people by listening to feedback, asking people their views and improving how the service was delivered.

People and staff felt that the service was well led. They told us that staff and the registered manager were experienced, understood people's needs, were approachable and listened to their views. The provider and registered manager continued to develop business plans to improve the service.

People were often asked if they were happy with the care they received. The provider offered an inclusive service. They had policies about Equality, Diversity and Human Rights. People, their relatives and health care professionals had the opportunity to share their views about the service either face-to-face, or by using formal feedback forms.

Safe recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the service. The provider recruited staff with relevant experience and the right attitude to work with people who had mental health illness.

New staff and existing staff were given an induction and on-going training which included information specific to the people's needs in the service. Staff were deployed in a planned way, with the correct training, skills and experience to meet people's needs.

The provider trained staff so that they understood their responsibilities to protect people from harm. Staff were encouraged and supported to raise any concerns they may have. Incidents and accidents were recorded and checked by the provider to see what steps could be taken to prevent these happening again. Staff were trained about the safe management of people with behaviours that may harm themselves or others.

Staff received supervision and attended meetings that assisted them in maintaining their skills and knowledge of social care.

Staff understood the challenges people faced and supported people to maintain their health by ensuring people had enough to eat and drink. Pictures of healthy food were displayed for people and dietary support had been provided through healthy eating plans put in place by dieticians. Staff supported people to maintain a balanced diet and monitor their nutritional health.

There were policies and procedures in place for the safe administration of medicines. People had control over their medicines. Staff followed these policies and had been trained to administer medicines safely.

People had access to GPs and their health and wellbeing was supported by prompt referrals and access to medical care if they became unwell. Good quality records were kept to assist people to monitor and maintain their health.

The quality outcomes promoted in the providers policies and procedures were monitored by the management in the service. Audits undertaken were based on cause and effect learning analysis, to improve quality. All staff understood their roles in meeting the expected quality levels and staff were empowered to challenge poor practice.

Management systems were in use to minimise the risks from the spread of infection, staff received training about controlling infection and carried personal protective equipment like disposable gloves and apron's.

Working in community settings staff often had to work on their own, but they were provided with good support and an 'Outside Office Hours' number to call during evenings and at weekends if they had concerns about people. The service could continue to run in the event of emergencies arising so that people's care would continue.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People experienced a service that made them feel safe.

Individualised and general risks were assessed to minimise potential harm.

Staff knew what they should do to identify and raise safeguarding concerns. Management understood how to report safeguarding concerns and notified the appropriate agencies.

The provider used safe recruitment procedures and general and individual risks were assessed. Medicines were managed and administered safely.

Incidents and accidents were recorded and monitored to reduce risk.

Is the service effective?

Good

The service was effective.

People's needs were assessed.

People accessed routine and urgent medical attention or referrals to health care specialists when needed.

People were cared for by staff who knew their needs well.

Staff encouraged people to eat and drink to maintain their health and wellbeing.

Staff met with their managers to discuss their work performance and each member of staff had attained the skills they required to carry out their role.

The Mental Capacity Act 2005 was understood by the management and staff received training about this.

Is the service caring?

Good

The service was caring.

Staff used a range of communication methods to help people engage with their care.

People had forged good relationships with staff so that they were comfortable and felt well treated.

People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Staff provided care to people as individuals. People were provided with the care they needed, based on a care plan about them.

People could take part in activities and socialise according to their lifestyle choices.

Information about people was updated often and with their involvement so that staff only provided care that was up to date.

People were encouraged to raise any issues they were unhappy about.

Is the service well-led?

Good

The service was well led.

The provider operated systems and policies that focused on the quality of service delivery.

There were new localised management structures in place to monitor and review the risks and quality improvement that may present themselves as the service was delivered.

Staff understood they were accountable for the quality of the care they delivered.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 14 March 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. The inspection was carried out by one inspector and an inspection manager.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

Two people told us about their experience of the service. We spoke with three staff, including the registered manager, and two care workers. We received feedback about the service from three health and social care professionals.

We looked at records held by the provider and care records held in the office. This included three people's care plans and the recruitment records of three staff employed at the service and the staff training programme. We viewed a range of policies; medicines management; complaints and compliments; meetings minutes; health and safety assessments and quality audits.

The service had been registered with us since 23 February 2017. This was the first inspection carried out on the service to check that it was safe, effective, caring, responsive and well led.

Good

Is the service safe?

Our findings

One person told us, "Very safe, much better here, you get skills development and we practice fire drills." Another person said, "It feels safe, I get on well with others living here." The person then went on to describe how they felt safe with the way their medicines were managed.

Health and social care professionals we spoke with were very complimentary about the service and people's safety. A community psychiatric nurse (CPN) said, "If I had a family member who needed this kind of service would use it. Staff are very professional but friendly."

People's needs had been fully assessed and care plans had been developed on an individual basis. Staff completed an assessment with people, their psychiatrist and the community psychiatric nursing (CPN) team or their relatives. Before people moved into the service an assessment of their needs had been completed to confirm that the service was suited to the person's needs. After people moved into the service they and their families where appropriate, were involved in discussing and planning the care and support they received. The assessments of care and care plans were consistent with good practice in community mental health services. There was a heavy emphasis on information and assessment from psychiatrist and the community psychiatric nursing (CPN) teams. Assessments and care plans reflected people's needs and were well written. Care planning happened as a priority when someone moved in. We could see people's involvement in their care planning was fully recorded.

People were safeguarded by staff who were trained to protect people from harm and understood their responsibilities to report concerns. Staff followed the provider's policy about safeguarding people and this policy was up to date with current practice. Staff had access to information so they understood how abuse could occur. Staff understood how they reported concerns in line with the providers safeguarding policy if they suspected or saw abuse taking place. Staff had read and understood the provider's whistleblowing policy. A member of staff said, "Safeguarding is covered as part of our induction with a test at end." Another member of staff said, "We [staff] are very open. We do not hide anything." Staff we spoke with gave us clear details of how they look out for and report concerns, both internally and if needed by blowing the whistle externally. Staff gave examples of what they would look out for, such as changes in people's behaviours, routines, medicines not being taken or physical signs of harm like bruising.

There had been five recorded safeguarding notifications in the last twelve months. These had been appropriately reported and investigated under the 'Multi-agency safeguarding vulnerable adults: Adult protection policy, protocols and guidance for Kent and Medway.' (This document contained guidance for staff and managers on how to protect and act on any allegations of abuse). The registered manager and staff had taken steps to minimise risk of safeguarding incidents by working closely with people and their CPN.

People were protected from harm through assessments and open and transparent risks management processes. The registered manager understood how to protect people by reporting concerns they had to the local authority or CPN's. Staff encouraged people to attend their regular CPN meetings and medicine

reviews. People had been assessed to see if they were at any risk from their behaviours and mental illness. The risks and vulnerabilities people faced living with mental illness fluctuated and this was taken into account by the registered manager. As the risks to people from their mental health increased, the staff interventions increased as well to ensure people's mental health remained as stable as possible. For example, if people became unwell and self harmed, staff would adapt their approach in line with guidance from a CPN. Where risk had been identified, the steps staff needed to follow to keep people safe were well documented in people's care plan files. Additional risks assessments instructed staff how to promote people's safety at times when their mental illness declined. For example, if people became more vulnerable in their local community due to changes in their behaviours more staff time was made available.

There were systems in place to monitor and collate incident and accident data to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again. Risks were reduced by consensus and with respect to people's independence. There had been three accidents recorded. The records showed that management were investigating and reviewing the accident reports and monitoring for any potential concerns. This ensured that risks were minimised across the service and that safe working practices were followed by staff.

Risks to people's individual health and wellbeing were assessed. Each person's care plan contained individual risk assessments including assessments of people's mental health care needs, diet and hydration and communication. CPN's were involved in planning and reviewing people's mental wellbeing. Where risks were identified, people's care plans described the actions care staff should take to minimise the risks. Staff signed support plans and risks assessments to acknowledge they understood them. When we spoke to staff they confirmed they understood potential risks and how these were minimised. Risks were discussed, communicated within the team and recorded at shift handover meetings and in team meetings. Records detailed the information shared between staff about risks within the service. This meant that the risks people may be exposed to were minimised.

The registered manager assessed risks to the environments people lived in to protect them and staff from potential hazards. Essential supplies such as the water, gas and electricity were the responsibility of the premises landlord, but staff and relatives told us that the premises were kept well maintained and that people had access to a list of maintenance companies they could call if things went wrong. People were involved in choosing how their home was decorated. The registered manager liaised with the housing provider to make sure works they were accountable for were completed. For example, prior to the inspection a water pie had burst in one of the corridors and damaged the ceiling and potentially the electrical wiring. We saw evidenced that this area had been made safe and in the process of being repaired. Responding to maintenance issues protected people from environmental risks.

Staff with the right skills supported people in the right numbers to be able to deliver care safely. Staff were experienced in caring for people with a mental illness. People were mainly independent with most of their life skills and staff were not required by people all of the time. We could see that the way staff were deployed matched people's needs in their care plans. The staff duty rotas demonstrated how staff were allocated on each shift. We reviewed the rotas, which showed that the required number of staff were consistently deployed. The rotas supported that there were sufficient staff on shift at all times. If a member of staff telephoned in sick, the staff member in charge would ring around the other staff to find cover. The registered manager made themselves available to cover shifts and was on the staff rota. This showed that arrangements were in place to ensure enough staff were made available at short notice. We saw that there were enough staff to supervise people and keep them safe.

People were protected from the risk of receiving care from unsuitable staff. New staff had been through an

interview and selection process. The registered manager followed a policy, which addressed all of the things they needed to consider when recruiting a new employee. Applicants for jobs had completed applications and been interviewed for roles within the service. New staff could not be offered positions unless they had proof of identity, written references, and confirmation of previous training and qualifications. All staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding.

People were protected from the risks associated with the management of medicines. Staff followed the provider's policy on the administration of medicines which had been reviewed and was up to date. People mainly managed and stored their own medicines in line with their individual rights. This was supported by recorded audits carried out by trained staff and by an external pharmacist. Appropriate assessments had been undertaken for people around their ability to take their medicines and whether they had capacity to make informed choices about medicines. This process included people's CPN. Staff who assisted people to administer medicines, for example by prompting, received regular training, competency checks and yearly training updates. Staff understood how to keep people safe when administering medicines. There was a policy about the safe management of 'As and When Required Medicines' (PRN), for example paracetamol.

There were systems in place so that medicines were available as prescribed. The system of medicines administration records (MAR) allowed for the checking of medicines, which showed that the medicine had been administered at the right times and signed for by the person when they had taken their medicine. We sampled the MAR records and these had been completed correctly. This meant that people's health and wellbeing was being maintained through the appropriate use of prescribed medicines.

In this supported living service, staff checked the fire alarm systems and assessed people's abilities to respond to evacuation drills. Records showed that safe systems of work had been implemented via regular health and safety checks of people's home.

The registered manager had policies about protecting people from the risk of service failure due to foreseeable emergencies so that their care could continue. There was an out of hours on call system, which enabled serious incidents affecting peoples care to be dealt with at any time. People who faced additional risks if they needed to evacuate had a personal emergency evacuation plan written to meet their needs. People and staff received training in how to respond to emergencies and fire practice drills were in operation. Records showed fire safety equipment was regularly checked and serviced. A staff member said, "Fireman came to do face to face training for fire marshals." Assessing and reducing risks to people from foreseeable emergencies protected people from potential harm.

People were protected from potential cross infection. The premises looked clean and staff received infection control training. Staff told us they always had access to personal protective equipment [PPE] when appropriate, such as disposable gloves and aprons.

Good

Is the service effective?

Our findings

One person said, "I sometimes do diner at home, staff help cook meals show me what to do. Brilliant key worker." Another person commented, "I feel the way the service is set up it's a great mix for you. As I can be independent, however I have support when needed."

Health and social care professionals we spoke with were very complimentary about the service and people's safety. A community psychiatric nurse (CPN) said, "The staff always respond well to agreed care provision to maintain people's mental health." A consultant psychiatrist said, "I have positive experiences of Mulberry House [in relation to staff in the service responding to professional recommendations]."

Another health and social care professional commented, "Mulberry offers an excellent service for the people with mental health problems placed with them. By responding appropriately to people in crisis working in collaboration with statutory services and providing appropriate support to move people on to more independent living where ever possible."

There was an initial assessment process in place checked the care and support needs of each person so the registered manager could make sure staff had the skills to care for the person appropriately. At the assessment stage people were encouraged to discuss their sexuality or lifestyle preferences as well as their rights, consent and capacity. The provider also assessed people's dependency levels to capture how much staff care was required and how independent people could remain. The provider's processes involved people and their family members in the assessment process when this was appropriate. Capturing information about people was an evolving process.

The initial needs assessment led to the development of the care plan. Individual care plans were detailed, setting out guidance to staff on how to support people in the way they wanted. Staff were required to record the care they had provided to people by recording how they had met people's needs in their care plan records. People's health and wellbeing was consistently monitored and reviewed in partnership with external health services. The registered manager contacted other services that might be able to support them with meeting people's health needs. This included the local GP, the community nursing teams, occupational therapist, and the community mental health team. People accessed a range of health and wellbeing services. For example, dental care.

This service was not providing food and drink to most people. However, where staff were helping people to maintain their health and wellbeing through assisting them to prepare meals, we found that people were happy with the food staff cooked for them. Where people's wellbeing was at risk from not eating and drinking healthily a plan was in place to monitor and respond to the risk. For example, with staff support people kept their own food diaries if they were at risks of gaining to much weight or not eating enough.

People benefited from staff who had appropriate training and skills to meet their needs. New staff completed an induction which included reading the service's policies and shadowing an experienced staff member to gain more understanding and knowledge about their role. They confirmed to us that they had

started with an induction. Staff then started to work through the training to Care Certificate standards which was recorded in their staff files. The Care Certificate includes assessments of course work and observations to check staff met the necessary standards to work safely unsupervised.

Training was provided to staff to improve their skills and understanding of people's needs and how to deliver care. The staff on shift told us they had received training to carry out their roles. Records showed staff had undertaken training in all areas considered essential for meeting the needs of people in a care environment effectively. This included statutory mandatory training, infection prevention and control, first aid and moving and handling people. Much of the training undertaken by staff was face to face training rather than computerised courses. Staff benefited from this type of training as they could ask questions to clarify their learning.

Staff received additional specialised training from a community psychiatric nurse, for example in the management of mental health. Mental health training was planned for staff. Training records confirmed that staff had attended training courses or were booked onto training after these had been identified as part of staff training and development. Staff receiving specialised mental health training meant that they understood the challenges people faced living with mental illness and how their needs could best be met.

The registered manager checked how staff were performing through an established programme of daily staff handover meetings, team meetings and formal supervision. These are one to one meetings and an annual appraisal of staff's work performance. This was to provide opportunities for staff to discuss their performance, development and training needs, which the registered manager was monitoring. We observed a hand over meeting between the morning and afternoon staff. We reviewed supervision notes from November 2017. These indicated managers were supporting a learning culture through discussion about important issues affecting staff work. For example, safeguarding and infection control. Staff confirmed to us that they had opportunities to meet with their manager to discuss their work and performance through supervision meetings.

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. Staff had received training in relation to protecting people's rights. This prepared them for any situation where they may think the Mental Capacity Act (MCA) 2005 needed to be considered as part of someone's care.

People's rights to consent to their care was respected by staff. People had choices in relation to their care. Care plans covered people's preferences about personal care and personal hygiene needs. The care plans made reference to promoting independence and helping to maintain people's current levels of self-care skills in this area. People or their representative had signed to agree their consent to the care being provided whenever possible. People living with mental illness often have fluctuating capacity in making day to day decisions. This was recognised by staff and advanced planning and decisions were made whilst people felt well about how they should receive care if they became mentally unwell. This meant that staff understood how to maintain people's individuality and respect choice.

People were free to do as they wished in their own home. Records demonstrated that the registered manager had a good understanding of the Mental Capacity Act (MCA) 2005. There was an up to date policy in place covering mental capacity.

Good

Is the service caring?

Our findings

People described their care positively. Staff we spoke with had the right attitude to care and were committed to delivering compassionate care. People told us that staff were kind, friendly and respectful. One person said, "I love every minute of it here and the staff are very kind and very helpful." Another person said, "Very relaxed here the manager and staff are very supportive."

Health and social care professionals we spoke with were very complimentary about how caring the staff were. A community psychiatric nurse (CPN) said, "Always visit the service and find relaxed friendly staff." A consultant psychiatrist said, "[Mulberry offers] a very personalised and caring service."

The care people received was person centred and met their most up to date needs. People's likes and dislikes had been recorded in their care plans. Staff encouraged people to be as independent as possible. All of the people who provided feedback told us they were involved in planning their care. We observed good communication between staff and people living at Mulberry House, and found staff to be friendly and caring. Best interest meetings about important decisions were recorded. People with changing capacity to make day-to-day decisions about their care were still offered choice and provided with information to help them decide what they wanted to do.

Staff we spoke with saw their roles as enablers for people. Staff told us about how they assisted and encouraged independence rather than just doing things for people. One member of staff said, "My colleagues have the right attitude to care." Another member of staff said, "We try and be good listeners and try and break down tasks into easy steps for people." Another member of staff commented, "I feel here at Mulberry House, we really strive to support and promote individuals choice and independence. We work in a person centred approach and put all clients at the centre of their care. We have a family culture here at Mulberry and really try and ensure that all our clients feel this."

The staff we spoke with were aware of what was important to people and were knowledgeable about their preferences, hobbies and interests. They had been able to gain information on these from the 'Person centred care plans', which had been developed through talking with people and their relatives. This information enabled staff to provide care in a way that was appropriate to the person.

People living with mental illness often suffer discrimination. The provider had a range of policies setting out their approach to dignity, equality, diversity and human rights (EDHR). These were accessible to staff and EDHR choices were included in people's initial assessments. Staff received training about the culture of the organisation in promoting dignity and human rights. Staff knowledge of EDHR was discussed at recorded supervisions meetings with the registered manager. Staff we spoke with demonstrated to us how they delivered care respectfully. This meant that care was open and inclusive.

Staff we spoke with were friendly and happy to provide care. Staff were tested on their attitude to care when they applied to work at the service. All of the staff we spoke with displayed a caring attitude. We found that people were supported by caring staff that were sensitive in manner and approach to their needs. Staff

described how they delivered friendly compassionate care. They told us how they made sure that people were comfortable and relaxed in their presence. Staff described how they made sure people had all they needed. Each person had a named key worker. This was a member of the staff team who worked with individual people, built up trust with the person and met with people to discuss their dreams and aspirations.

Information about people was kept securely in the office and the access was restricted to senior staff. The registered manager ensured that confidential paperwork was regularly collected from people's homes and stored securely at the registered office. Staff understood their responsibility to maintain people's confidentiality.

Good

Is the service responsive?

Our findings

One person said, "I would make a complaint, [if needed] the process is on wall in hall. Since moving in I have felt at home, got things for my room from a [high street store]." And, "I am working on becoming more independent. I now do my own washing machine; Very happy so far."

A health and social care professional commented, "The manager and his staff go all out to provide support for the residents. There is open dialogue between staff and my service users, so any concerns can be dealt with quickly and efficiently."

People received personalised support which met their specific needs. A member of staff commented, "The clients are comfortable to speak to staff about sensitive matters as well as everyday conversation, and get supported with visits to doctors and other appointments where requested."

The support people received was based on promoting mental health recovery and moving to independence. People felt the service was meeting their aspirations to become as independent as possible. Their needs were reviewed and kept up to date and this was confirmed in people's records and by staff. People told us that they had a care plan folder in their home with information in it about their care. Records showed that people had been asked their views about their care. People told us they had been fully involved in the care planning process and in the reviews of those plans. Reviews of the care plan could be completed at any time if the person's needs changed. Where changes were identified, people's plans were updated promptly and information about this was shared with all staff. We could see that care plan reviews had taken place as planned and that these had been recorded.

Mental health support care plans detailed early interventions based on people's individual needs. This enabled staff to intervene early if they saw people's mental health deteriorating based on known patterns of behaviour. Staff understood the recorded behavioural triggers for each person. If people's needs could no longer be met at the service, the registered manager worked with the local care management team to enable people to move to more appropriate services. The registered manager sought advice from health and social care professionals when people's needs changed.

Staff encouraged and motivated people to remain engaged with their local community to reduce isolation. People followed their own routines and had minimal staff support in the community. However, they could request support for activities including participating in leisure activities, going to the pub for lunch and personal shopping. Staff were allocated to people's activities based on their skills and experience. This meant staff could understand and meet this person's individual needs. Staff helped people to stay in touch with their family and friends.

Records of multi-disciplinary team input had been documented in care plans. These gave guidance to staff in response to changes in people's health or treatment plans. Information was displayed for people to access about health services and advocacy support. This meant that there was continuity in the way people's health and wellbeing were managed.

Staff told us they read people's daily reports for any changes that had been recorded and the registered manager reviewed people's care notes to ensure that people's needs were being met. When we spoke with staff they showed that they knew people well and what was important to them. This was evidenced by the knowledge and understanding they displayed about people's needs, preferences and wishes. The staff were able to tell us how they provided people with care that was flexible and met their needs. For example, they told us how they assisted people with physical care needs, emotional needs and their nutritional needs.

People we spoke with felt at ease to raise concerns with care workers or any member of the management team. Each person had a named key worker. This was a member of the staff team who worked with individual people, built up trust with the person and met with people to discuss their dreams and aspirations. We saw from care plans that when people had met and chosen activities these had been organised by their key worker and they recorded when they had taken place. People had one to one meetings with staff. At these meetings people were encouraged to talk about any concerns or complaints they had about the service. Staff understood that people with mental health issues may not always be able to verbally complain. Staff compensated for this by being aware of any changes in people's mood, routines, behaviours or health.

The provider had a comprehensive complaints and compliments policy that included information about how to make a complaint and what people could expect to happen if they raised a concern. The complaints procedure was openly displayed in the service. The policy included information about other organisations that could be approached if someone wished to raise a concern with an external arbitrator, such as the local government ombudsman. There had been no complaints received in the last twelve months. The service staff had also received six recorded compliments in the last year. All people spoken with said they were happy to raise any concerns. The registered manager always tried to improve people's experiences of the service by asking for and responding to feedback. The meetings and communication in the service reduced the risk of situations requiring people to make complaints.

Good

Is the service well-led?

Our findings

People knew who the management team were and were confident to approach them with any problems or concerns. Everyone said that the service was well run. Comments included, "The manager builds a good staff team up. And, "The manager comes in and does extra shifts, the staff are very reliable." People who replied to our questionnaire gave 100% positive feedback about the management of the service.

The service was well led by managers who maintained their skills and understanding in mental health issues. The registered manager had developed their skills to Health and Social care Level 5 and was training to be a person centred therapeutic counsellor to promote person centred work and autonomy for people . A community psychiatric nurse (CPN) said, "The registered manager communicates well, this is an excellent service." Staff said, "The manager is very approachable, hardworking and immensely dedicated to the people we support."

The provider had clear values which was promoted by the registered manager to all staff. The culture of the service was open and inclusive. Staff we spoke with consistently demonstrated the provider's values to help people regain their confidence and continue to live independently or with little support. The aims of the service at Mulberry House was to offer a wide range of information on activities and events that will help tenants to build confidence, self-esteem and knowledge. From feedback we received these aims were being delivered for people.

Staff understood who they were accountable to, and their roles and responsibilities in providing care for people. Staff told us that they work closely with the registered manger and provider who also worked shifts at the service. People and staff told us that these managers were approachable and supportive, and they felt able to discuss any issues with them. One member of staff said, "Team meetings are a good place to let others know if you are struggling communication is key. We always make sure colleagues are up to date. After incidents we do a debrief, asked how has it affected us, what support can we put in place, how do we feel about it."

Management worked with the commissioners of the service to review people's needs to ensure the service continued to be able to care for them effectively. Referrals had been made to health professionals for advice and training and staff followed recognised practice for delivering community mental health services.

There were systems in place to review the quality of all aspects of the service. This included infection control, medication, safety of the premises, staff records, training and care planning. Appropriate and timely action had been taken to protect people from harm and ensure that they received any necessary support or treatment. There were auditing systems in place to identify any shortfalls or areas for development, and action was taken to deal with these for example, refresher training for staff. Records showed that auditing process were kept up to date. These checks were carried out to make sure that people were consistently safe.

People were asked for their views about the service in a variety of ways. These included monthly keyworker

meetings, house meetings and one to one discussions with people about their care. People were asked about their views and suggestions; events where family and friends were invited; and there was daily contact with management and staff. The registered manager commented, "When receiving our surveys back from clients, families and professionals we aim to respond appropriately." For example, a relative feedback that it would be easier for their family member to move to a downstairs bedsit due to poor mobility, and another relative mentioned it would be nice for their family member to move to a bigger room. Therefore when a vacancy came up downstairs, it was agreed to move one person downstairs to meet their mobility needs, which then allowed the other person to move into a bigger room. It was reported that both people and their families were extremely happy with this.

There were a range of policies and procedures governing how the service needed to be run. They were kept up to date with new developments in mental health and social care. Management was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team. Management understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the service. This ensured that people could raise issues about their safety and the right actions would be taken.