# Complete Care Services Limited

# Mulberry House

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Following the last inspection in February 2018 when the service was rated as inadequate overall, we met with the provider and asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Effective, Caring, Responsive and Well Led to at least good.

At the last inspection we found an inadequate level of leadership at the home, fire safety checks were not complete, plans to promote people's safety were also not complete. Safety checks on new staff to ensure they were safe to work at the home were not taking place. There were low levels of staff on shift. Staff were working long hours despite supporting people with high needs and often with low staffing numbers. Staff training was not effective. There were institutionalised practices in relation to people having drinks. Healthy food was not available. People whose weight was low were not being supported to increase their weight. The environmental condition of the home was poor. People were not being supported to explore their interests. There were no regular social events taking place. The provider was not completing meaningful and effective audits.

We inspected the home again six months after the report was published. We found some improvements had been made. However, there were still areas which required further work. Where improvements had been made further time was needed to see if these improvements were effective, sustained and embedded into the culture and practice of the home. Further work was also needed in terms of the culture of the home.

The overall rating for this service is now 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This service has therefore remained in special measures.

When we inspected the service on 11 October 2018 we rated the service as 'Requires Improvement' overall. This inspection was unannounced.

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

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

The care service had not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as

ordinary a life as any citizen. Registering the Right Support CQC policy. However, some progress had been made to start to develop the service in line with these values.

There was not a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider was recruiting for this post.

At this inspection we found some unsafe practices in relation to how infection control was managed at the home. The storage and disposal of people's medicines were not always being managed appropriately. People's safety in and outside the home was not being consistently promoted by staff actions and by effective risk assessments and plans. Incidents, accidents, and a safeguarding event were not always being managed in a way which ensured people were safe. Lessons were not being learnt from these situations to protect people's safety in the future.

Staff were not consistently kind and respectful to people at the home. The provider was not always valuing people at the home by promoting standards in their environments.

Plans had been put in place to improve the leadership of the service and day to day management oversight of the home. However, the provider had not provided appropriate temporary management cover while there was no registered manager in post. Given the changes needed at the home more management support and presence was needed.

Quality monitoring audits by the provider had improved but they were still not robust checks identifying flaws in staff practice, and risks to people's safety. Still the upkeep and maintenance of the home environment was an issue. The provider was unable to see short falls in this area and act to resolve them. This made us question the values of the provider in respecting people at the home and their ability to promote their rights.

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

Following the last inspection there were more staff on shift to meet people's needs. Staff told us that the quality of the training had improved. Although, there was no longer a registered manager in place staff spoke positively about the current leadership of the service. Staff found that the provider visited more frequently and they were approachable.

Staff knowledge about how to protect people from abuse and discrimination had improved, but further work was still needed in these areas.

Staff now had a clear understanding about how to promote choice and people's freedoms.

The service was starting to look at promoting healthy food options. More work was required in how they promoted people's meal experiences and choices of meals and drinks.

People had experiences of activities and events with some planned trips taking. The leadership of the home were starting to ask people about what they wanted to do and find ways to broaden people's interests and wishes.

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

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Risks to people's safety were not always being managed in a safe way.

Risks to people's safety were not always being identified by staff and the management of the home.

Accidents and incidents were not always managed effectively.

There was more managerial oversight of the service but this did not always improve staff practice.

Staffing levels had increased.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

There were shortfalls in staff knowledge and skills.

People's dining experiences was not being promoted. People's food choices were sometimes limited.

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

People were supported to access health services.

Staff competency had started to be assessed.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

The environment of the home and people's rooms looked uncared for.

Staff did not always treat people in a kind respectful way.

People were encouraged to be independent with elements of

their day to day life.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People's rights were not always promoted at the home.

People did not always have complete assessments and plans in place.

There were now more activities and planned events taking place.

People's ambitions were starting to be explored and identified.

## Is the service well-led?

**Inadequate**

The service was not well led.

The provider audits were not always robust and did not always promote people's rights and encourage the service to do better.

Daily monitoring of staff practice was not always effective or in place.

There was leadership of the service, but this still needed to be improved upon.

Staff felt able to approach the provider and deputy manager.

# Mulberry House

**Detailed findings**

## Background to this inspection

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

The inspection was carried out on 11 October 2018. This inspection was unannounced. The inspection team consisted of one inspector.

Before the inspection we made contact with the local authorities' contracts team and safeguarding team. We asked them for their views on the service. They made positive comments about the service. We looked at the statutory notifications that had been sent us over the last six months. Statutory notifications are about important events that the provider must send us by law.

We had not received a Provider Information Return report. 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. This is because we had not asked for this report. We reviewed the action plan the provider had sent us following the last inspection.

Most people were unable to communicate with us in ways which we could understand. As a result of this we completed many observations of people who lived at the home. During the inspection we spoke with three people who lived at the home. Two members of care staff, and the deputy manager. We looked at the care records of three people, the medicines records of four people and the recruitment records for three members of staff. We completed observations of staff practice and interactions between people at the home and the staff. We also reviewed the audits and, safety records completed at the home.

Requires Improvement

# Is the service safe?

## Our findings

When we inspected Mulberry House in February 2018 we found it was unsafe. When we inspected the home in October 2018 some improvements had been made. However, we found other issues which showed that the support people received was still not always safe.

At this inspection we found that accidents and incidents were not always processed in a safe way. One person had sustained cuts to their face while staff supported them to shave. This event was recorded but there was no plan in place or lessons learnt from this situation. We spoke with the deputy manager about this. They later told us about the plan and action taken to support this person in the future when they had a shave.

This person had also sustained a bruise around their eye. The service had not investigated this. Assumptions were made and no plans were put in place to manage this potential risk in the future. A safeguarding referral was made to the local authority as potential abuse had been identified. However, this referral was made two days later and not at the time this incident was discovered. In both cases neither the manager or the provider identified in how lessons could be learnt in how these situations were managed.

We found equipment used was not safe for the purpose intended. A person had two metal knobs on a wall in their shower cubical which were the remains of an old shower system. A tennis ball had been placed over one of these metal knobs. Staff told us that the tennis ball was in place as this person often sits in the shower and could hit their head as they stand up. The provider had not removed the metal knobs. We were later told however staff planned to do this.

In another person's bedroom we saw a razor blade on the bedside table and there was another unsecured razor blade in their bathroom. The person lacked capacity in key parts of their life. The access to razor blades had the potential to be a risk to this person and others. The deputy manager agreed this person and others could be at risk with unsupervised access to the razor blades.

We observed the cupboard containing cleaning products was left open. There was a pad lock on this cupboard but this cupboard had not been closed and locked after a member of staff had opened it. We told the deputy manager about this who then locked it. We also found that a person had three highly flammable products next to one another in their bathroom. This had not been identified as a potential risk with action taken to minimise this risk.

At the last inspection we noted that a fire door was not closing when the alarm was activated. The device to make it close when the alarm was triggered had now been removed. This door was always kept closed during our inspection. However, we saw that one person pushed this heavy door open abruptly and other people were near to it at the other side of the door. On two occasions we saw that two people were nearly hurt but the risk had not been identified by staff. We spoke with the deputy manager about this. They told us that this would be resolved.

At this inspection we found some unsafe infection control practices which could put people at risk of becoming unwell. In one person's bedroom we found a used incontinence pad and gloves in their waste paper bin. The deputy manager asked a member of staff to dispose of the contents safely. We found gloves placed on a person's shelf in their room. These had no packaging and could have been worn.

A person living at the home showed us outside. We noticed that there was an infection control bag filled with used items. This was on the ground. The general waste domestic bin next to it had an open infection control bag with used items in it. The deputy manager told us that these bins would be left outside until the weekly waste collection. These bins and their contents were exposed which meant that this was not a safe way to store these items.

We asked the deputy manager about how staff disposed of used incontinence items. They told us that staff put them in people's waste paper bin, and then take the bin to the bin outside and then disinfect the waste paper bin. These items were not sealed. Staff took these items through the home to access the back garden where the bin was. We also noted that in one person's bathroom they had a rusty toilet roll holder. This is also a risk to the spread of infection.

We identified a risk to a person's safety. A person had a risk assessment in place due to the risk of them falling when using the stairs at the home. Professional advice had been sought who advised that continuous supervision is provided when this person used the stairs. Their care plan also said that staff should carry items for this person. We saw this person using the stairs. A member of staff had given them some items to take to their room. They were needing to take two steps up the stairs, bend to put these items down, then take some more steps, and bend again to pick them up. This member of staff was not promoting this person's safety or following the guidance when this person used the stairs to reduce their risk of falling.

At the last inspection a person had gone missing while out in the community. Some work had been completed on this plan. However, there were still gaps in this plan. For example, staff did not know where this person went when they went into town. Their risk assessment had identified the situations when they could get lost. Staff were not identifying where this person liked to go or asking this person where they might be going and recording this. There had been no work attempted with this person in relation to finding a 'safe place' in town if they got lost.

Some risks were not always identified or explored. For example, one person had diabetes. There was no information about what this person's diabetic needs were. Also, there was no information about how this person can present as unwell because of their diabetes. Or what action should staff take at these times. This person also had issues with maintaining a healthy weight. The risks this posed to this person and how staff should help this person to manage this need were not explored.

The above issues constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We completed a check of people's medicines to see if people had received their medicines as prescribed. We looked at people's medication administration records (MARs) and we found that one person's medicines had not been signed for on two occasions. We counted this person's medicine with the deputy manager and we both agreed that this person had received this medicine. However, their MAR was not accurate.

We also looked at people's prescribed creams. The staff were now monitoring the temperature of the rooms where these medicines were stored. However, they were not recording when these items were opened. These items should not be being used three months after opening them. As they may no longer be medically effective.

Another person had a collection of batteries in a plastic container in their opened bathroom cabinet. These batteries looked old and some were rusty. There was a rusty fluid in the base of this container. We showed this to the deputy manager who removed these from this person's room.

The staff had a good understanding about what abuse could look like. They said they would report their concerns to the deputy manager or to the provider. Staff knew there were outside agencies they could report their concerns to. However, they did not have these agencies contact numbers. They had not noticed the safeguarding poster displayed in the home detailing this information. Staff also told us that they would talk to the member of staff who they suspected had caused harm to a person. This is not safe practice and could undermine a local authority investigation into a potential allegation of abuse.

Staff had a better understanding about discrimination than they had at the last inspection. These members of staff knew what a 'hate incident' could look like. However, they were not clear on what they should do if a person experienced 'hate' in the community.

Staff told us that staffing levels had increased. We looked at the 'worked on rotas' and we saw that three members of staff were on each shift. At the last inspection sometimes only two members of staff were available.

Staff were still working 12-hour shifts despite being around people who often expressed high energy and who needed a lot of support. Staff told us that they were fine with this length of shift now there was consistently more staff on shift. However, they also recognised that some people needed a lot of support who lived at the home. The deputy manager told us about plans to reduce staff's shifts to 6 hours to respond to this issue and then see if this was an improvement.

We checked to see if the recruitment checks completed when staff started working at the service had improved. The deputy manager told us about the home's new policy not to start a new member of staff's induction until they had a cleared Disclosure and Barring Service (DBS) check in place. Since our last inspection no new staff had started working at the home so we could not check this had happened.

At the last inspection there were gaps in staff employment histories. At this inspection there were still gaps in these records. The deputy manager told us that work had not been carried out on this area yet. The deputy manager also told us that the provider had changed the new staff application forms, to now ask for a full employment history.

People had personal emergency evacuation plans (PEEPS) in place. However, these plans were not in the emergency bag. Also, it was not clear if staff knew what to do if a person refused to leave the home in this type of event.

Safety checks on the vehicle used at the home were now taking place, to ensure it was safe to use, each time people used it. Various fire safety checks were also taking place including a weekly fire drill and evacuation drill. There had been a visit by the fire service to check the building was fire safe. Fire related equipment had been serviced to check it worked if needed.

The home's emergency plan had improved. There was now detailed practical information for staff to follow. However, further work was needed to ensure staff had seen the plan and were aware of what to do in the event of all emergencies.

Requires Improvement

# Is the service effective?

## Our findings

When we inspected Mulberry House in February 2018 we found areas which required improvements to be made. At this inspection in October 2018 we found that some improvements had been made. However, improvements were still required to be made

At this inspection we still found short falls in staff's knowledge and their understanding of key areas of their work. We found issues with the disposal of a used medicine, infection control, keeping people safe, responding to injuries and sometimes with how they responded to people. This questioned how effective the training was for staff. It also questioned how robust the oversight was of the day to day management of staff.

The provider and management of the home were not considering the use of technology or aspects of the layout of the home to meet people's needs.

Following from the last inspection in February 2018 we could see that staff were now having competency checks. In some cases, these were well evidenced, but some were not. We spoke with the deputy manager about these checks. They told us of the plans they had to improve these checks.

The staff we spoke with were positive about the training they now received. Staff told us that this was a real improvement from when we inspected the home in February. We asked staff how the training was better. One member of staff said, "You feel good, you understand, it's not boring, you have different trainers so it is more interesting."

Following the last inspection, the provider had arranged for a new training company to plan and deliver the training. One member of staff told us about the additional vocational training they had been supported to complete.

The deputy manager also told us about the plans to 'upskill' senior staff to perform quality checks at the home, and how they were going to do this. However, we looked at the training matrix and we could still see that some training subjects had not been revised for three years.

People were being supported to have enough to eat and drink. People ate their food and appeared to enjoy it. We saw an improvement from our last inspection that those people who needed to gain weight were given more food to eat. People's weight was being monitored on a regular basis. However, these records still did not guide staff about what to do with the results of taking these people's weights. This is an area that requires improvement to ensure people are supported to maintain a healthy weight.

Some work had started about promoting healthy foods at the home but as the deputy manager told us, more work was needed in this area. We still saw some examples of staff adhering to set times for drinks. Although we saw that other members of staff did not do this. We told the deputy manager about this who told us they would revisit this issue with staff. A poster detailing these times was still present in the kitchen.

This is an area that requires improvement to ensure people are supported to be healthy and have choice and control with their drinks.

Menus had been devised by asking people what they wanted to eat. However, staff did not explore alternatives with people. One member of staff told me that they asked people again what they wanted for dinner, to check that they still wanted it. However, we saw them telling people what was for dinner. No alternatives were offered. One person looked unsure before lunch that they wanted the meal of baked beans on toast. Time was not spent with this person considering the potential options available to them. This member of staff walked away from this person after they had said two food items and the person looked confused and began to get upset.

We again looked at people's dining experiences. We found that staff were not promoting this. Staff either sat and watched people eat or they ate their food away from people, but in the same room as people eating their food. On one occasion one member of staff was eating and drinking something different to what people were eating and drinking. This meal option which had been cooked in the kitchen, had not been explored with people as a potential option for them. At another time two members of staff sat in the dining room working out the money for the evening trip while people ate their dinner.

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 a clear understanding of what capacity meant and how they promoted choice with people's daily care needs. One member of staff said, "It's about being patient, giving them (people at the home) space to make a decision."

We looked at people's care records and found that people's capacity assessments were detailed. However, we looked at one person's capacity assessment to take their own medicines. The member of staff completing the assessment had shown that this person had the capacity to manage their medicines. However, a health professional on this person's behalf had made the decision that staff were to manage this person's medicines. Staff therefore managed and administered this person's medicines which may not have been in line with their wishes. This issue required further clarification by speaking with this professional and with this person, but the assessor had not done this.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Some people living at the home had a DoLS in place. The staff we spoke with could tell us what a DoLS was. They were also able to relate it to some of the people at the home. One person now had a DoLS in place responding to a restriction of their cigarettes, which was not in place before.

When people needed support to maintain their health staff took action. We saw examples of people having routine health appointments. We also saw examples of staff making GP appointments when people were not well.

Requires Improvement

# Is the service caring?

## Our findings

When we inspected Mulberry House in February 2018 we found that the service was not always caring. We found that the provider was not treating people with dignity due to the upkeep of the environment. When we inspected in October 2018 we found this was still the case.

When we inspected the home in February this year we found that there were issues with the up keep and maintenance of the building and people's rooms. An improvement had been made with the provider replacing the double-glazing units in the home. Previously the double glazing had failed which made it difficult to see outside. The provider had rectified this issue at this inspection. However, we still found that there was a lack of action taken in terms of the up keep of the home. This impacts on how the provider and the management of the home values and respects the people at the home. The décor in people's rooms was tired. Paintwork was marked, furniture also looked tired. In one person's bathroom the flush was not fully working this was known, but no action had been taken. An old discoloured sponge was placed behind a shower unit, to support the direction of the shower head, a person had metal knobs protruding into their shower cubical. Still people did not have curtains and blinds in their bathrooms.

At times staff did not speak with people in a kind or respectful way. We saw two people asking staff what was for dinner that evening. Two members of staff separately responded to these people by saying, "I've already told you that." These were direct statements to these people and said in an unkind tone. On one occasion a member of staff pointed to the person as they said this. Another person began talking to us about a subject they often spoke about. We saw a member of staff look at us and raise their eye brows. This was not respectful. We did not believe staff meant to be unkind or disrespectful. This was a training need where further attention was required in this area.

A person started speaking with a member of staff, they stated that they wanted something and started crying, this member of staff turned away from them and said, "Alright, alright." The tone was abrupt. They then did not support the person with what they were asking for.

When we saw these examples of unkind practice, they were not challenged by other members of staff who were present at that time.

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

Despite this we also saw examples of staff being kind and thoughtful to the people at the home. We saw one member of staff talking with a person to reassure them about something which had upset them. A person played a game and another member of staff congratulated them. This person clapped and looked happy about this.

Most people could not communicate with us. However, we saw that people were familiar with the staff. When the deputy manager came into work a group of people living at the home welcomed the deputy

manager and hugged them.

We saw that people were being more involved in the planning of their care and sharing their views of the support they received. People were being supported to maintain their independence within the home in terms of daily domestic routines and accessing the community when they wanted to. People's confidential information was also secure in the home.

Requires Improvement

# Is the service responsive?

## Our findings

When we inspected Mulberry House in February 2018 we found that the service was not always responsive to people's needs. When we inspected Mulberry House in October 2018 we found improvements had been made, but there were still areas which needed further development.

People did not always have complete care assessments and care plans which reflected their health and physical needs. In the sample of three people's care records two people's health needs were not explored. When we spoke with the deputy manager about this they told us that this person's diabetic plan was down stairs on a notice board. When they showed us this, this was in fact a general information leaflet about their health need, pinned on the wall. This was not a person-centred plan detailing for staff what action they should take to meet this health need.

Another person's care record was not up to date in terms of the risks which they faced or with how a part of their life was being restricted in their best interests. One person could express behaviour which challenged other people. This was identified and explained in their assessment. However the staff response was not explored and explained in their care plan.

People still did not have end of life plans in place. The deputy manager told us that a person in the home had recently experienced a bereavement. So, they and the provider had decided this was a sensitive area for people at the moment. However, they had not provided training for staff as a start to address this area of development.

Staff referred to people as "Service users" or "Clients." We saw that on two occasions staff referred to people in this way in front of them. Paper work about the home also used this language. At times staff were not promoting the home as people's own home and space.

One person had made a panel to go up at their window. This was made from an old cardboard box. They had decorated one side of it with stickers and glitter. It was positive that this person had been supported to design their own panel to give them some privacy, but the service had not considered if they could do more to promote this person's dignity and interests in this situation.

There had not been any formal complaints made about the home or compliments. We could see there was information on a notice board in pictorial form telling people how to make a complaint. However, this was not being promoted and then recorded as part of people's one to one meetings or group meetings.

Despite this there was good information about people's personal histories and who were important to them. The deputy manager showed us how they had tried to involve people in the planning of their care. We saw examples of people stating they had been involved with elements of the planning of their care. Following our last inspection, the deputy manager had improved people's one to one meetings with staff. It was clear to see from looking at these records that people were being asked about what they wanted to do in terms of meeting their interests. These records also showed what action was taken to ensure these wishes were

fulfilled.

Improvements had been made in terms of activities and events at the home. People had recently asked for a party. Plans were made, and the party took place. People had been out to events. Plans were being made for further trips out. On the day we inspected the home in October plans had been made for people to go out to the theatre, people at the home looked excited about this. Staff commented on how the provider had really invested into this area of people lives. Staff listed the places and trips people had experienced.

During this inspection we saw staff encouraging daily activities and games. We saw some staff chatting to people and trying to encourage their involvement with activities. However, there were times when we observed staff putting the TV on and not always asking people what they wanted to watch. Staff were seen watching the TV programmes and were not engaging with the people around them. One member of staff on two occasions positioned themselves directly in front of the TV, this member of staff did not ask what people wanted to watch.

We concluded that improvements in providing social opportunities for people had been made. However, improvements were still required to promote the home as people's own home, and ensure staff had the support, skills and resources to meet people's interests.

Inadequate

# Is the service well-led?

## Our findings

When we inspected Mulberry House in February 2018 we found that the leadership of the home was inadequate. When we inspected the home in October 2018 we found that some improvements had been made. However, the issues found had still not all been resolved.

When we inspected in February 2018 there was no daily clear leadership of the home. The registered manager was not present on a regular basis, there was no deputy manager in place, and no senior staff leading the shift. Following the February inspection, a deputy manager had been appointed who knew the service well. Seniors on each shift were in place and the deputy manager told us about the plans they were making to 'up skill' these members of staff. We spoke with one of these seniors who told us about the additional training they had completed. The registered manager had left the service when we recently inspected and the provider was now recruiting for this role.

Staff told us that the provider was now more involved in the service. They told us that the provider visited the home on a regular basis and had attended staff meetings. Staff told us that they now felt confident to talk to the provider and make suggestions and raise issues.

The provider had completed one provider audit since our last inspection. This was a detailed report detailing how they had conducted their assessment of the home. This was an improvement from previous records of audits completed.

Despite this the provider audit and the provider visits, of which we were told took place most weeks had not identified the issues which we had found at this inspection. In terms of short falls of staff practice. Certain risks to people's safety not being identified, explored, with a robust plan in place which staff were aware of. Infection control issues. Accidents and incidents not being processed and responded to effectively to ensure people's safety. The ability of the management team to learn from mistakes made. Poor record keeping in relation to staff rotas and staff training. Gaps and delays in staff training and knowledge. The safe storage of people's prescribed creams. The approach of some staff towards people at the home.

The provider still was not promoting people's dignity in care. They were not promoting people's day to day quality of life via the environment of the home. We identified issues with the upkeep and maintenance of the home which the provider had not found. The provider's audit had identified some repair issues. However, the provider had given these issues a long time frame to resolve. When one person's bathroom was identified as needing redecorating and they declined there was no evidence to say how this subject was approached and the options that were explored with this person. This person was only given one opportunity to consider this. Plans to redecorate their bathroom were delayed until January 2019, no other plans to revisit this subject were made. Other rooms which were in greater need of work were not identified at all. There were no plans in place about these issues.

During this inspection we spoke about the décor and condition of people's furniture. We were told that one person's furniture was being replaced. The deputy manager told us on two occasions that the reason for this

is this person had the funds to replace their furniture themselves. as this is a care service which provides the accommodation the provider should be funding this.  When we advised them of this we later received a correspondence saying the person would not be buying their own furniture. However, there were no plans to replace or repair other people's bedroom furniture at the home.

At times there was evidence of a poor culture at the home. In terms of how some people were spoken to by staff and how some staff reacted when people expressed some challenging behaviour. The provider demonstrated a limited awareness and ability to also promote people's daily quality of life. The provider and the management were not assessing and checking the day to day culture of the home.

Further work was required by the provider to ensure that the service was being delivered in line with the values that underpin 'Registering the Right Support'. To ensure people are always valued as individuals, they have choice, independence and are included as much as possible in the running and development of the service.

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

We were not notified about a safeguarding event which was raised by the home. The registered manager (while in post) had not notified us about all the important events which they must do by law. While there was no registered manager in place the provider had not ensured there was a robust system in place to ensure these types of events are reported to us.

The management of the service had not involved people, and other organisations in the development of the home. There was no evidence of strong links with the community.

Staff told us that they now felt comfortable and confident approaching the deputy manager. One member of staff said, "[Name of deputy manager] listens to you and does something about it." Another member of staff told us, "I really respect [deputy manager] they will make a good manager one day."

Staff gave us examples of raising issues with the deputy manager and the provider and action being taken to resolve these. Staff told us that this element of the culture of the home was changing for the positive. They told us that they hoped it continued to change.

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 10 HSCA RA Regulations 2014 Dignity and respect<br><br>Regulation 10 HSCA 2008 (RA) Regulations 2014: Dignity and Respect<br><br>The provider had not ensured that people are always treated with dignity and respect.<br><br>Regulation 10 (1) and (2). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br>Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment<br><br>The provider had not ensured that care and treatment was provided in a safe way. They had not assessed all risks to people's safety or taken appropriate actions to mitigate these risks.<br><br>Regulation 12 (1) and (2) (a) (b) (c) (e) (h). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance<br><br>The provider had failed to have effective systems and processes in place to monitor and |

improve the safety and quality of the service provided.

Regulation 17 (1) and (2) (a) (b) (c)