Mulberry Court Healthcare Limited

Mulberry Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this unannounced inspection on 19 and 21 April 2016.

Mulberry Court Care Home is a registered to provide personal care for up to forty three people. At the time of our inspection there were fifteen people using the service. Mulberry Court was newly registered in November 2015. People began using the service in early February 2016.

Mulberry Court Care Home is a two storey home situated in the middle of a housing estate in Bilborough, a suburb of Nottingham city. There are 43 single rooms with shared bathroom facilities. There is a communal lounge and separate dining room. There is a reminiscence area. Outside is a garden area but this is not yet fully accessible for people who live at the home.

At the time of our inspection, there was no registered manager in place. The manager of the home had applied to become the registered manager and was waiting for their registration application to be processed. 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.

People at the home told us they felt safe. Staff we spoke with could identify the different types of harm and knew how to raise any concerns.

The risks to people's health and safety were not always adequately managed by the service.
It was not clear whether people were receiving their medicines as prescribed, as accurate records regarding the administration of people's prescribed medicines were not always kept.

The environment was not always clean and hygienic. We saw some of the seating areas were stained, and found waste bins with no lids. The bath and shower chairs were not clean and we saw a red dirty laundry bag left in the bathroom.

Not all staff had received the relevant training and support to enable them to meet people's care and support requirements. Staff supervisions had not yet been put in place where staff could discuss any issues they may have, and where they could review and agree their skills and development needs.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and report on what we find. The manager had submitted applications to the local authority for authorisation of Deprivation of Liberty Safeguards [DoLS] where it was identified this this was required for people who lack mental capacity. However, there was an inconsistent use and understanding of the MCA by the manager and staff.

People were given a sufficient choice of meals and drinks. Any potential risks around malnutrition were not always adequately assessed and acted upon. People did not always receive adequate support or supervision in relation to any risks at mealtimes, such as people who required prompts and encouragement to eat their meals.

A range of external health professionals were involved with people's care such as GP's, dentists, opticians, and the dementia outreach team when people had changing health conditions but staff did not always follow instructions and recommendations made by external health and social care professionals.

Some people had developed caring relationships with staff, but we observed other people received a more task focused approach with their support. Care planning documentation did not always evidence people's involvement in planning their care, and not all the people we spoke with felt they were involved in planning their care in a way that was personal to them.

People's dignity, privacy and respect was not always fully promoted. Some bedroom doors did not close properly, and we observed staff sometimes talking to people in front of others about things that were personal to people. Staff did not always ask people's permission before providing their care.

People's records did not always contain enough information regarding their personal preferences and choices to enable staff to provide the care in a way that people preferred. People from different ethnic backgrounds did not always have their individual cultural needs met.

The provider had recently recruited an activity coordinator. Activities were being organised for people. Some people were being assisted to access the community.

There was a complaints procedure in place, but people told us that they did not know how to make a complaint. The service did not demonstrate learning from complaints.

People found the manager was approachable. Staff meetings and handovers were taking place.
Some quality audits were taking place, but these were not always highlighting, or taking forward some of the issues with the service.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this report.

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 health and safety and well-being were not always managed.
Accurate records were not always kept to show that people were having their medicines as prescribed. Medicines were not always stored safely.

Staff were aware of their roles and responsibilities in relation to safeguarding. Staff were recruited safely. Staffing levels were not always sufficient to ensure people kept safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training and support required improvements to ensure staff had the necessary skills and competencies to carry out their roles.

When people lacked mental capacity to consent to their care and treatment, assessments and best interest decisions had not always been made appropriately or completed.

People had a choice of meals, and sufficient amounts to eat and drink. People did not always receive adequate support and supervision with their meals, and any nutritional risks were not always monitored.

Is the service caring?

Requires Improvement

The service was not always caring.

Whilst some people had developed meaningful relationships with staff, other relationships were more task focused.

People's privacy, and dignity were not consistently respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans lacked detail and information that was required to ensure people received the right care and support for their individual needs.

There was an activities coordinator, and some people were being assisted to access the community.

There was a complaints procedure, but complaints were not adequately documented or learned from.

Is the service well-led?

Requires Improvement

The service was not always well lead.

People and staff did not always feel supported by the management of service.

There was a manager in post who was in the process of registering with CQC.

Some audits were carried out, but these did not always identify areas that required improvement. The service did not always learn from previous events and experiences.

Statutory notifications were being sent to CQC as required.

Mulberry Court Care Home

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.

This inspection took place on 19 April and 21 April 2016 and was unannounced. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We carried out the inspection by talking to six people who used the service, and eight relatives. We spoke with the manager, deputy manager, the owner of the service, a senior care staff member, four members of care staff, the hospitality manager and a cleaner. We looked at four people's care records. We observed the medication round, and people's lunchtime experience. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We checked three staff files, and looked out some of the provider's policies and procedures. We checked environmental safety checks and records. We spoke with two visiting healthcare professionals.

Before the inspection we contacted the local authority commissioners and the local Healthwatch group to request any feedback. We checked records of the statutory notifications received from this service. Statutory notifications contain details of important and significant events about which providers are legally obliged to tell CQC.

We checked to see if there was a Provider Information Return. 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. They did not return a PIR and we took this into account when we made the judgements in this report. After the inspection we spoke with two social care professionals and a healthcare professional to obtain their views

Requires Improvement

Is the service safe?

Our findings

Staff told us they had received training in safeguarding adults and knew what actions to take if they felt a person was at risk.

Although some risk plans were in place, they were not always completed. For example we saw falls risk assessment that was not fully completed and did not take previous risk factors into account. This meant that the risk of falls for the person was not accurately calculated. Other records that we looked at did not contain risk assessments for people in relation to their nutritional needs. We also saw risk plans were not always being reviewed. One person's risk regarding mobility had not been reviewed since February 2016.

We were told a person fell during our inspection. The person's care plan documented that the person should be supervised by staff, but did not say how often or for how long this supervision was required. The person was not being supervised at the time of this fall. The care plan did not contain sufficiently detailed guidance to inform staff what level of supervision was required by the person. We found that the falls risk assessment not been totalled correctly for this person, and had therefore been scored as low risk. This was incorrect as the person had a past history of falls. We also noted that the person's falls care plan was not completed. This meant that management did not always manage and monitor the assessed risks to people to keep them safe.

During the first day of our inspection, the fire doors were frequently being opened, causing the alarm to activate. On two occasions when talking to staff, they assumed that when the alarm sounded, it was a false alarm and did not get up to investigate until prompted by ourselves. Later that day, a person exited the building by the fire exit, again causing an alarm to activate. Staff did respond and follow the person. The manager told us that special magnetic fastenings were on order for the fire doors which would make them more secure, as once these fastenings were in place they would only be released in the event of a fire alarm.

Another person's risk plan indicated they were a high risk of choking, but the plan did not give detailed information to staff on what to do if the person were to choke. There was no detailed information on how the person should be supervised by staff when eating or drinking. We saw that the person was sat alone whilst eating their meal and was coughing heavily throughout. Staff did not react to this. We raised this as a concern with the manager during this inspection.

A person was at high risk of pressure ulcers. The person's care plan stated that they were no longer able to change position independently. The person had an alternating pressure mattress in place. However, there were no repositioning charts or any evidence that this person was being assisted to change position by staff in order to minimise the risk of pressure ulcers.

This is a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

In relation to staffing, one person told us, "They are very short staffed all day." A relative said, "The home is extremely understaffed. They [staff] are looking after more [people] than they are capable of."

Staff we spoke with also felt the home were short staffed. One staff member told us, "We are rushed off our feet." Another staff member said, "People are put at risk. If we are busy with a double up, and [person's name] is restless….there are a room full of other people left and it's not safe."

We saw a visiting health care professional with a person who required a dressing putting on a wound. There was no staff in the vicinity to stay with the person whilst the health professional went to fetch a dressing. The health professional told us they could not leave the person. A staff member arrived after several minutes. Again, this demonstrated that there was not sufficient staff to meet the needs of people.

The manager told us the service was not using a dependency tool to work out safe staffing levels at that time. The manager told us what they believed that staffing levels should be; the staff rota showed these levels were usually matched except when staff were unwell or on leave. Two staff members had recently left and agency staff were being used to cover any gaps. The manager told us that they tried to get the same agency staff to ensure consistency.
Another staff member told us they did not have time to read people's care plans. This is important as care plans can tell staff about people's needs, risks and preferences.

We observed a person, whose care plan said they required a staff member to walk alongside them, frequently getting up by themselves. On two occasions, there were no staff in the vicinity to assist the person. We intervened and activated the call bell system. The manager was the first person to respond the call bell. This was a concern as it showed us there were insufficient staff to respond to the needs of people using the service.

The manager told us that three more staff had been recruited, but were waiting for recruitment checks, and that recruitment was ongoing.

These examples demonstrated to us that there were not enough staff to safely meet people's needs.

This is a breach of regulation 18 of The Health and Social Care Act 2008(Regulated Activities) 2014.

The manager told us that she assessed staff medicine administration competencies, and all senior staff had received assessments in administering medicines. However, when we checked the staff record, we found that one person who was administering medicines had not received the training. Their training records demonstrated that the member of staff, who was responsible for managing people's medicines, was out of date.

We observed a person refuse to take their medicines. The person had asked the staff member what the medicines were for but the staff member was unable to explain to the person the purpose of their medicines. We noted that the person was also not happy when they saw the amount of medicines they were being asked to take. The person refused to take their medicine at that time.

We saw that a staff member had to ask a relative how their family member liked to take their medicines. The relative also asked the staff member for a specific aid for their family member when taking their medicine, and the staff member was unable to find this aid. This aid was required to enable the person's medicine to be taken in the most effective way.

A staff member told us that any staff member could witness administration of medication. We were concerned that staff who witnessed medicines being administered also required training to safely undertake this task. This meant that we could not be sure that staff acting as the second checker of

medicines were adequately trained to undertake this role.

We found the medicines fridges were unlocked, and there were gaps in temperature recordings. Not all of the Medicine Administration Records (MARs) had photographs of people in them to aid with identification, or details of any allergies the person may have, and how they liked to take their medicines.

We saw a number of MARs had gaps in the recording. This meant that it was not clear to us if people receiving their medicines as they needed them. We found that some instructions for staff on medicines dosage were not clear as to whether one or two tablets should be taken. Some people were prescribed medicines on an 'as required' (PRN) basis. However, we saw very few guidelines for staff around PRN medication, and the dose of PRN medicine was not always recorded when it had been given. When people required creams to be applied, it was not recorded consistently whether or not they were getting these creams. We also saw eye drops that had not been dated when opened.

When people were prescribed dietary supplements, there were not always recorded as being given on the MARs. This means we were not sure that people were getting the dietary supplements that had been prescribed for them.

This is a breach of regulation 12 of The Health and Social Care Act 2008(Regulated Activities) 2014.

We saw satisfactory checks had been made on the safety of the building and equipment, such as electrical circuitry, gas, and the equipment such as the lift and mobile hoists. We found that three wheelchairs had out of date service stickers, and we raised this with the manager, who told us that the wheelchairs had been serviced, and would send us this information by the following week. This information has not been received. Individual evacuation plans were in place for people in the event of a foreseeable emergency such as a fire.

A relative told us that the general communal areas were clean but their family member's bedroom was not clean. On the first day of our inspection, one of the tables in the dining area still had food traces on it several hours after the midday meal. A person had been making pizza as part of the afternoon activity. This was wrapped in foil and left in a very warm lounge area until late afternoon. The warmth of the environment could have increased the risk of the food being spoiled and posed a risk to people's health.

We found stained wipes in the toilet area of one bathroom that had not been disposed of, and not all waste bins were lidded.. We saw a bath chair and a shower chair that were not clean, and a bathroom contained a red laundry bag with soiled linen in it.

At the time of our inspection, a person had a infection that could have been transmitted, but we were not made aware of this until later by one of the kitchen staff. Although staff had taken some protective measures to reduce the risk of infection spreading, there was no clean or dirty distinction in the laundry facility.

Some areas of the home did not have paper towel dispensers, but we saw from the infection control audit done by the provider in April 2016 that these are on order. Several of the toilets did not have hand wash or paper towels on the first day of inspection, that these had been replenished by day two of our inspection.

People told they felt they were safe with Mulberry Court Care Home. A person told us, "I am safe and I like it here." Another person told us, "I am happy and safe here." A relative said, "[My family member] feels safer here than anywhere else."

Staff we spoke with had received training to recognise the different types of harm and knew the procedures

for reporting possible harm. A member of care staff said, "I think people are safe here. I would report any concerns to a senior in charge or to the manager."

During this inspection staff we spoke to told us that they had pre-employment checks carried out before starting work at the service. We saw records that confirmed that pre-employment safety checks were carried out prior to them starting work and providing care. Checks included references from previous employment. A criminal record check that had been undertaken with the Disclosure and Barring Service (DBS), proof of current address, and photographic identification. These checks were in place to make sure that staff were of a good character and that they were suitable to work with people using the service.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with told us they had undertaken a period of induction in which they had carried out both online and face-to-face training on subjects such as safeguarding adults, assisting people to move, and food hygiene. A staff member said, "The training really helps me to do the job."

The manager told us that it was mandatory for all care staff to complete the Care Certificate. The Care Certificate is a nationally recognised set of minimum standards endorsed by the Skills for Care Council, which is good practice to abide by. However, staff we spoke with were not all clear whether or not they had completed the Care Certificate.

The manager told us all staff had completed safeguarding training. According to the training records, two of the care staff team had not received any training on safeguarding, several staff had not received practical training in moving and handling, and two care staff had not received any training on Mental Capacity Act 2005 [MCA] and Deprivation of Liberty Safeguards [DoLS].The deputy manager has since infomed us they were updating staff training.

None of the staff we spoke with had received any supervision since working in the service. A staff member told us, "I've not had supervision yet." We asked the manager about this. The manager told us that they had a matrix of supervisions planned, but this was not yet in place. We saw some informal notes recorded of meetings between the manager and staff members where concerns had been raised, but these did not give clear guidance on what steps would be taken next.

We saw a staff member effectively calm a person who was becoming very upset and anxious.We spoke to a professional after the inspection, who said that some of the less experienced staff struggled to manage people with behaviours that challenge. The professional told us that they had been assured by the home's management team that training would be given to the staff to learn how to deal with behaviours that challenge, but this still had not taken place as far as they were aware. Staff training records supported this.

We concluded that the provider was not appropriately providing staff with the required induction, support and training to ensure staff's competence was maintained.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The 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.

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. The application procedures for this in care homes are called the

Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

When we people's checked care plans, two of the people for whom a DoLS had been applied for, had not had a mental capacity assessment completed.

We saw the care plan for a person stated to be living with advanced dementia, but there was no mental capacity assessments or best interests decisions in their records in relation to decisions that may need to be made about their care and treatment.

Another person's care plan stated they were no longer able to self-medicate, and required full assistance and support with their medication. The pre-admission assessment stated that this person 'lacked capacity', but there was no reference to the MCA in the person's assessments in relation to the person taking medication or to any best interest decisions having been made.

Some of the templates for mental capacity assessments contained in the care plans were blank. There was a mixture of knowledge about MCA and DoLS in the staff we spoke with. We spoke to the manager and raised our concerns. The manager agreed that further work was clearly required in this area.

The manager told us that three applications for DoLS had been made to the local supervisory body. They said that they were awaiting authorisations for these applications.. The manager told us that they would apply for DoLS authorisation if someone was trying to leave the building or if there was a locked door. Since a Supreme Court ruling in March 2014 the law in relation to DoLS has changed. We recommended to the provider that they sought guidance and training about this new legislation in order to be following the legal changes correctly. This meant we were not confident that the service was providing care for people in line with the legal requirements of the MCA This demonstrated that staff had insufficient knowledge and use of the MCA legislation.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people had behaviour that challenges others. Staff we spoke with showed a good awareness of how to manage this by using diversionary tactics. A staff member told us, "If a person refuses personal care, we leave them, and then go back and try again later." Another staff member said, in relation to a person who often tried to leave the service, "We try to take [person's name] for a walk outside before they get to the point where they are unhappy."

Staff were clear that restraint was not used but during our inspection, we saw a staff member remove one person's walking aid in order to stop them from repeatedly getting up. We raised this with the manager, as this was a form of restraint. The staff member was an agency worker, and the manager said that they had already raised concerns with the agency at the end of the first inspection day.

A person told us the food was good but said, "I don't like a lot salad at the time and there is no other choice." However we did see people being offered a choice at mealtimes. Another person said, "The food is excellent and lovely. "A relative commented, "The quality of the food is lovely. Dinners and breakfast look very nice."

The kitchen had recently been inspected by the local authority and had been awarded a five star rating. This is the highest rating for hygiene that can be awarded. The service had all of the relevant checks in place to ensure that food was stored and served correctly to protect people's health. There was a board in the

kitchen where any special diets were recorded, and could easily be seen by kitchen staff. We also saw a record of people's individual likes, and dislikes, and preferences. Catering staff told us the menu was rotated every five weeks.

There were no visible menus for people. The hospitality manager told us that staff plated up small portions of each choice of meal to give people a visual choice, and assist people living with dementia to choose more easily. However, we did not see this happen on either of the inspection days. This meant that it was more difficult for people living with dementia to be able to make informed choices about their meal preferences.

We observed, and people told us, that there was a choice of cereals or a cooked breakfast, and a choice of two hot meals and two desserts at lunchtime. The serving of the meals was quite a long process, with people sat at the table for up to 15 minutes before their food arrived. We saw some people were getting impatient. A person said, "Is anyone serving?" and also "I just asked if anyone was coming?"

We saw staff checking that people had finished their meals before removing their plates. People were asked if they wanted any more to eat, and if they had sufficient.

There were no jugs of juice or water on the tables, but staff brought drinks round to each individual and as their preferences. Similarly there were no condiments such as salt and pepper on the tables, therefore people were unable to help themselves to these items as they chose.

From our observations we saw that staff tended to interact with people who had no communiataion difficulties , and it was noticeable that the people who were less able to express their needs had less interaction with staff apart from more task focused care.

We saw in records that people were weighed every month, but there were no risk assessments regarding nutrition.

One person's records stated that they should be weighed weekly, but when we checked the weight for this person, they had been weighed twice in March only. The care plan for this person stated they were reluctant with eating and drinking, but there was no records of any daily food and fluid intake. We saw the person holding their spoon the wrong way round at lunchtime, but staff only spent a minimal amount of time prompting the person and encouraging them.

The care plans we looked at stated what each person's optimum fluid intake per day should be, but no one was have their fluid intake recorded so it was not possible to say whether the person was having their recommended daily intake as recorded in the care plans. The manager told us that when the people first came to the home, their food and fluid intake would be monitored for three days. If there were no concerns after this point, this would then cease.

We observed a person who was coughing heavily when eating and drinking. We raised our concerns with staff, who told us that they thought a referral to the speech and language therapist had been made. In the meantime, the person was being given a soft diet. We raised our concerns with the manager. We checked the records for the person which showed that an urgent referral had been made on 20th April 2016, the day after our first inspection.

We saw and people told us that health professionals were called when people needed them. A GP visited during our inspection, and also a nurse from the falls team. We saw from records that professionals from the Dementia Outreach Team had also been called for a person. We also saw a dentist had been called for a

person who had a broken denture. However staff did not always follow instructions and recommendations made by external health and social care professionals. For example, one person required their weight to be monitored weekly, but this was not being done. Staff had been requested by healthcare professionals to use ABC charts for a person with behaviour that challenges. Again these were not being completed.

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Requires Improvement

Is the service caring?

Our findings

A person told us, "I like it here, they care for me." Another person said, "I am well looked after; they do care for me." A relative commented, "Staff are lovely. They are very attentive." However some feedback was mixed . Another relative added, "Staff are very caring." One person said there had been a lot of staff changes and that they didn't always recognise staff. A staff member told us, "I enjoy helping people, talking with them, hearing their life stories, and just being there for them." Another staff member said, "We are patient and attentive."

Staff we spoke with talked about people and in a respectful and caring manner but we did not always observe care being offered in a respectful way. For example, at lunchtime we saw a staff member move a person from the table without asking their permission or acknowledging them in any way. A visiting professional said they felt staff, "did not have a full understanding of care processes."

We saw that people who were less able to communicate verbally appeared to receive support that was more task-focused, with less personalised interactions. For example, we saw a staff member leaning against a wall. We asked the staff member to assist a person whose nose was running. The staff member gave the person tissue and left. A second staff member gave the person a dessert without asking. The person coughed back into the desert and it was taken away by another staff member.

Some of the people we spoke with were unable to tell us if they were involved in planning their care due to living with dementia. There was a mixed feedback from relatives about how involved they were in planning their relatives' care. One relative told us they were not involved in care planning, but another family said, "We were involved with the setting up of the care." There was a lack of signatures in care plans from relatives or people using the service. Some of the care plans did not contain personal histories. This is important as it can enable staff to have more knowledge of the person before supporting them.

A staff member told us they involved people in their care by asking about people's life histories to develop their care plans. The staff member added, "We ask what they want and give them choice."

One person said, "Staff always knock on my door and are polite." One relative told us, "My [family member] would like their own key to their room." This relative went on to say that some people walked in and out of other people's rooms and therefore their family member wanted to be able to lock their door as they wished. We raised this with the manager who agreed to supply a key immediately.

A relative told us that staff did not always check with people before providing care. The relative stated, "They just tend to do it." We observed a staff member at lunchtime putting an apron on a person without asking their permission or explaining what they were doing. We saw another staff member move a person's chair away from the table, again without asking permission or giving any explanation. We saw staff knock on a person's door, but they went in to the room without waiting for an answer.

The care records we saw were not always person centred, and did not give details on people's preferences

and routines regarding their care and support.

Staff we spoke with told us how they have protected people's privacy and dignity. A staff member commented, "You always do personal care behind closed doors, with the curtains closed." Another staff member stated, "We don't talk about people in front of others. It is confidential."

We saw that some bedroom doors did not close fully at times, and staff were not always careful to make sure the door had closed fully before providing support for a person in their room. We also overheard staff talking to other staff or professionals about a person in front of that person, without acknowledging them or involving them. This was also in front of other people using the service and visitors. From what we observed and what people told us, we were not always confident that people's dignity and respect was always promoted.

There was information on advocacy services available, but no one was using these at the time of our inspection.

Requires Improvement

Is the service responsive?

Our findings

A person told us, "I have a choice what time I go to bed and wake any time I want. They ask what I wanted for breakfast." A relative told us, "Sometimes staff don't come quickly." They added, "I'd like more individualised care for my family member. I would like to feel I can leave my relative here long term."

Two people living at the service were unable to speak in English. Although the family of one person could provide some assistance, the other person had no one to communicate with. Over the course of the inspection we observed this person to be isolated. The care plan stated that the person did not speak English and that the person preferred to stay in their room. We were not confident that the person was able to express their needs and wishes due to the language barriers.

The person told us, "I find it difficult to settle in the home as there is no one who can communicate, and my English is poor." We overheard a visitor saying it was good that someone was talking to the person. The person told us that they wanted to visit their place of worship. However, this had not been actioned as staff were unaware of this, due to being unable to understand the person's language. The provider had, however, arranged for Sky television to be installed, so that the person could watch a TV channel that spoke their own language, in their own room.

Care staff told us that they had given this person some communication cards but we did not see these being used during our inspection, nor were they referred to in the person's care plan. The manager told us that the owners sometimes spoke to the person. We discussed with the manager about making a referral for an independent advocate for this person. The manager told us that the service had recruited two members of staff that spoke the person's language, but the staff had not yet started work at the service.

Another person who had recently come to live at the service could no longer speak English. We saw in the person's records that staff and asked the person's family to bring in religious statues, pictures and candles for the person's room, in keeping with the person's religious beliefs.

We reviewed the care plan documentation for four people at the service. One person's care plan showed there were gaps in the personal hygiene chart which may indicate personal hygiene was not given on these days. Similarly nothing was recorded on a bowel chart for 12 days. A visiting professional told us this person was severely constipated.

Another person had no position change charts, despite the care plan stating they were at risk of pressure damage. The person was complaining of a sore lower back. On the second day of our inspection, the person was sitting at the dining table in a wheelchair over an hour after lunch had finished, despite calling out to be moved.

A person living with dementia had recorded in their daily records several instances of behaviour that challenges. Although the service had contacted the Dementia Outreach Team, they had failed to follow through the instructions given by the Dementia Outreach Team, such as completing ABC charts, and

encouraging the person to use the commode in their room throughout the day because of differing floor surfaces. On the first day of inspection, we could not find a care plan for this person in relation to managing their behaviour that challenged. We raised this with the manager, and a care plan was in place when we returned on the second day.

We saw that some of the care plans we looked at had not been reviewed since February 2016. The manager acknowledged the care plans still required work.

The service had recently recruited an activities coordinator. Relatives told us, "Staff keep [person's name] motivated and give her lots of exercise." We saw one person playing dominoes with the activity coordinator, but this did not give other people a chance to become involved. The other people were to left to occupy themselves.

We saw the activity coordinator bring some knitting needles and wool for a person. We also saw them offer some magazines to a person. A relative told us they had seen a number of activities taking place, including Ludo, Domino's, jigsaw puzzles. An external entertainer came in during the inspection and did singing.

Earlier in the day we observed a group of people making pizzas in the dining room. Staff we spoke with told us that some of the people liked to go out. One person enjoyed going to the local pub, and another person liked to go to a market. This was confirmed by a health professional we spoke with.

A person told us, "I do not know the manager or how to make a complaint." A relative said, "I really don't know what to do if I wanted to make a complaint." However, they also said they would not have any problems raising concerns and were confident to do so.." A staff member told us, "Complaints would be listened to." The manager told us they had had a verbal complaint which they had dealt with. We asked for a copy of the investigation. The manager gave us some brief handwritten notes, but there was no evidence of analysis or learning from the complaint.

There was a copy of the complaints procedure in the main entrance to the service, but this was not in an accessible format to all people. The manager also showed as a comments and suggestions box in the main entrance, but no one had used this.

Requires Improvement

Is the service well-led?

Our findings

The manager had reported a safeguarding to CQC in relation to an allegation of harm by a member of staff against a person living at the home. Immediate actions were taken to minimise the risk of a similar occurrence. However, the manager had failed to make a referral to the Disclosure and Barring Service.

A recent safeguarding referral from the ambulance service was discussed with the manager. It was acknowledged that the reason behind this was due to records that were required by the night staff had been locked in the office which were they were unable to access. The manager assured us that records would be made available to staff on all shifts following this event. However, a professional we spoke with after the inspection told us that staff had been unable to access some records since this time as the office was locked and they could not therefore gain entry.

No relatives or residents' meetings had yet taken place. The manager told us this was something that they were planning once the home had been open for six months. We saw that a staff meeting took place in early February 2016 and April 2016. The last meeting looked at improving communication, and the uniform policy.

The manager explained that they had allocated 'champions' within the home for areas such as infection control, hydration and dignity. The manager told us there were dignity champions, one of whom was themselves. Not all staff were aware of who the dignity champions were. Dignity champions believe that dignity is a basic human right, not an optional extra and aim to uphold dignity in care settings such as care homes. The manager showed us posters, but staff we spoke with were not aware of these roles, and could not say, for example, who the dignity champions were. This meant that the management were not communicating effectively with staff.

The manager told us that they were aware that 50% of the care plans still needed work to improve them, and said that they were working to improve the care planning processes. The manager stated that whilst they read through the daily support records, there was no written audit carried out either on these, or on the quality of the care plans.

The manager kept a record of accidents and incidents, but there was no analysis of any themes and trends of what had happened, or of any learning made in response to accidents. It was not clear from reviewing accident records that there was learning from past incidents to prevent recurrences.

The manager carried out a number of audits. The manager carried out medication competences every month. We checked the last audit the medication. We found that the audit did not identify the gaps in the medicine administration record charts, or the lack of dating of eye drops The audit had identified some issues, but no action plan had been put in place to address these.

The hospitality manager carried out a monthly infection control audit. Again, some issues such as a lack of lidded bins had been missed.

This is a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

A person told us, "I know the manager, but I can't recall the name." Another person said, "The manager is very informative and knows their stuff." Another person added that they felt able to talk to the manager, and a relative told us, "The manager is lovely; very kind." Other people were less confident, with some relatives saying, "The management has complete disregard for care of the residents. What quality of care is provided?" Staff we spoke with were positive about the manager, saying, "The manager is brilliant. Any concerns [I have] I can go and tell her. She is always willing to help." Another staff member said, "The manager is approachable and friendly."

Staff were aware of the whistleblowing policy and told us they were comfortable to raise concerns should the need arise. A staff member stated, "I would feel comfortable raising concerns if I had to. "The manager told us they carried out a 'daily walk round' to check for issues in the home and with people who lived there. Again, during the inspection we found a number of issues that had been missed. Some radiators with hot surfaces were not covered which could put people at risk of getting burned. There was no shower head for one shower, and some lights were not working, including lights next to the emergency exit. We raised these issues with the manager and provider. The manager and provider were open to receiving constructive feedback, and wanted to resolve any issues that were reported. Both said they wished to improve the quality of care for people at the home.

Registered persons are required to notify CQC of certain changes, events or incidents at the service. Records showed that we had been notified appropriately of such changes when necessary.

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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 11 HSCA RA Regulations 2014 Need for consent People were unlawfully deprived of their liberty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were put at risk of being unsafely administered their prescribed medicines. This was because safe medicines administration guidance was not followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The management failed to take action in response to safeguarding concern which could have impacted on people's safety. There was no learning or evaluation from accidents and incidents. Audits were not effective in identifying and rectifying issues found within the service. Care documentation was not adequate in demonstrating an accurate, up to date record for each person using the service. People had not been given opportunities to comment on their views of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not supported by sufficient

numbers of suitably qualified skilled or experienced staff