Barchester Healthcare Homes Limited

Mulberry Court

Inspection report

Clifton Park
Shipton Road
York
North Yorkshire
YO30 5PD

Tel: 01904671122
Website: www.barchester.com

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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 3 and 5 May 2016 and was unannounced.

Mulberry Court provides nursing and personal care for up to 64 residents. The home is purpose built and has accommodation and communal areas on all three floors. All floors can be accessed by a lift. The home has a licenced bar, an activities room and a garden. At the time of our inspection there were 57 residents using the service.

The service is required to have a registered manager, and at the time of our inspection there was a registered manager in post. 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 had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse, and staff we spoke with understood the different types of abuse that could occur and were able to explain what they would do if they had any concerns. We found that people's needs were assessed and risk assessments were in place to reduce risks and prevent avoidable harm.

The provider had a safe system for the recruitment of staff and was taking appropriate steps to ensure the suitability of workers. There were mixed viewed about the availability of staffing, but we found there were systems in place to ensure there were sufficient staff to keep people safe.

Medication was appropriately stored, administered and recorded on Medication Administration Records. Staff responsible for administration of medication had received training and the provider completed medication audits and staff competency assessments. This showed that there were systems in place to ensure people received their medication safely.

Staff completed a range of training to help them carry out their roles effectively, and there was a schedule for refreshing this training when it was required. The majority of staff were up to date with most of their refresher training, and there were plans to ensure any overdue refresher training was completed.

The registered provider sought consent to provide care in line with legislation and guidance. Staff had completed Mental Capacity Act (MCA) training and were able to demonstrate an understanding of the principles of the MCA.

People were supported to maintain good health and access healthcare services. We saw evidence in care files of contact with healthcare services, such as GPs, speech and language therapists, psychiatrists and opticians. There were mixed views about the quality and variety of food available, and the availability of support for people who ate in their own rooms, but people told us they got sufficient to eat and drink. The

registered manager and chef were working with people to increase the variety of food and accommodate individual preferences. There were refreshments available throughout our inspection. Care plans contained information about people's nutritional needs and preferences, and this information was also available to staff in the kitchen. People's weight was monitored and action taken where people had lost weight.

Most people told us that the staff who supported them were kind and caring. One person told us staff spoke across them to each other when providing them with support, however the registered manager told us this issue was being addressed. People also reported that they felt their privacy and dignity were respected. We saw that interactions between staff and people using the service were positive and friendly.

Care plans were reviewed monthly and contained information about people's needs, routines and preferences. Staff were also able to demonstrate a good understanding of people's needs and preferences. The home employed two activities co-ordinators and there was a range of leisure and social activities available to people.

There was a complaints procedure in place and most people using the service told us they knew how they could raise a complaint if they needed to. People also had opportunity to raise concerns or give their views in resident's meetings, food and activity forums, and through individual review meetings.

There was an effective quality assurance system in place, which included a range of audits and surveys conducted by the registered manager and deputy manager, as well as quality assurance checks conducted by regional management. This enabled the registered provider to identify issues and measure the delivery of care.

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.

There were systems in place to protect people from avoidable harm. Staff had been trained in safeguarding vulnerable adults and knew how to respond to any concerns. Risks to people were appropriately assessed and managed.

The registered provider used a robust recruitment process and appropriate checks were completed before staff started work, to ensure that people were supported by staff who were considered suitable to work with vulnerable people.

There were good systems in place to ensure that people received their medication safely.

Is the service effective?

Good

The service was effective.

Staff received a comprehensive induction and regular refresher training. Staff felt confident they had the training they needed to carry out their roles, and could request additional training if they needed it.

Staff were able to demonstrate an understanding of the principles of the Mental Capacity Act, and the importance of gaining consent before providing care to someone.

People were supported with their nutritional needs and had access to healthcare services, where this was required, in order to maintain good health.

Is the service caring?

Good

The service was caring.

Most people told us that staff were caring and that they had positive caring relationships with the staff that supported them.

People we spoke with felt that staff respected their privacy and dignity, and we saw that people's independence was promoted.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were in place to enable staff to provide personalised care. Staff demonstrated an understanding of people's individual needs and preferences.

There were systems in place to manage and respond to complaints and concerns, and to listen to the views of people using the service.

Is the service well-led?

Good

The service was well-led.

Feedback about the management of the service was positive and staff were provided with the support they needed to deliver the service effectively.

The registered manager promoted a positive and person-centred culture by providing opportunities for people and staff to express feedback about the service.

There were effective quality assurance systems in place.

Mulberry Court

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 3 and 5 May 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors.

Before our visit we looked at information we held about the service, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also received feedback from City of York Council's contracts and commissioning team.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of this inspection we spoke with 11 people who used the service and four visitors to people using the service. We also spoke with five care staff, two nurses, a chef, an activities co-ordinator, the training co-ordinator, the registered manager and the deputy manager. We looked at four people's care records, six people's medication records, four staff recruitment files, staff training files and a selection of records used to monitor the quality of the service.

Good

Is the service safe?

Our findings

We asked people using the service if they felt safe living at Mulberry Court, and everyone we spoke with said they did. People told us, "I feel safe," and "You feel safe here, it's pleasant."

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. All staff received training in safeguarding vulnerable adults from abuse as part of their induction training, then regular refresher training thereafter. Staff demonstrated a good understanding of how to safeguard people who used the service; they understood the different types of abuse that could occur and were able explain what they would do if they had any concerns. Care staff told us they would report any concerns straightaway to the nurse in charge or the manager. A nurse told us they checked for any sign of injuries, documented the concerns or injuries, and the manager then reported the concern to the local authority safeguarding team.

The registered provider also had a whistleblowing policy, which enabled staff to report issues in confidence and without recrimination. This showed that the registered provider had a system in place to manage safeguarding concerns and protect people from avoidable harm and abuse.

People had appropriate risk assessments in relation to their individual needs. These included assessments in relation to continence needs, falls, moving and handling, skin integrity, choking, use of call bells, pain and bed rails. The Malnutrition Universal Screening Tool (MUST) was also used to assess people's risk in relation to malnutrition. Risk assessments were reviewed monthly. We saw evidence that people had been involved in decisions about risk, and where people's choice to make what other people may regard as 'unwise decisions' about their care, such as declining to be repositioned, we saw that these were respected.

We saw that records of any accidents or incidents were stored in individual files, and a copy passed on to the registered manager, in order to ensure appropriate action had been taken in response to any incidents. The registered manager recorded information about accidents and incident's on the registered provider's electronic clinical governance system, so that data could be analysed in order to identity patterns and action required.

We looked at documents relating to the maintenance of the environment and servicing of equipment used in the home. These records showed us that service contract agreements were in place which meant equipment was regularly checked and serviced at appropriate intervals. This included alarm systems for fire safety and fire extinguishers, electrical wiring and the gas system and appliances. Checks also included legionella sampling, sprinkler systems servicing and servicing of the passenger lift and hoisting equipment. Maintenance staff at the service also conducted portable appliance tests on portable equipment. These environmental checks helped to ensure the safety of people who used the service.

The home had achieved a rating of five following a food hygiene inspection undertaken by the local authority Environmental Health Department in 2015. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Personal emergency evacuation plans (PEEPs) were in place for people who would require assistance leaving the premises in the event of an emergency. PEEPs are used to record the assistance people would need to evacuate the premises in an emergency, including any impairment they had, the support they would need from staff and any equipment they would need to use. The registered provider also had a business continuity plan detailing how they would ensure people's safety and comfort in the event of an emergency, such as a fire or flood.

When we spoke with staff about how they ensured people's safety they told us, "We keep people safe by constantly keeping an eye out, for trip hazards for instance, and by pre-empting people's needs. All risks are stated in the care plans, and what needs to be put in place to keep people safe. If someone has swallowing difficulties for example, there is a laminated poster in their room." Another told us about the importance of following risk assessments, noticing when there were changes in people's mobility and ensuring bed rails were used for those who needed them.

The registered provider had a safe system for the recruitment of staff. We looked at recruitment records for four staff. We saw that appropriate checks were completed before staff started work. These checks included seeking appropriate references, identification checks and registration checks for nursing staff. We saw that the provider also verified the references provided. The registered provider also completed Disclosure and Barring Service (DBS) checks. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. The recruitment records we viewed showed us that the registered provider was taking appropriate steps to ensure the suitability of workers.

We spoke with the registered manager, staff and people who used the service about the availability of sufficient staffing to meet people's needs safely. Staff told us, "Staffing is alright at the minute," "Staffing levels are really good, and they are good at covering holidays" and, "There have been good staffing levels since [registered manager] started. The unit manager allocates tasks and organises breaks." Another told us, "Staffing has improved. Since [registered manager] started they have employed a lot of new staff. Personally I think we could use another carer…in the afternoon it is busy and stressful." Another said, "[Staffing levels] are generally fine. Obviously you get staff sickness sometimes which can make it a bit tighter, but usually it's okay. We also work flexibly across the floors, so if one floor is short we will move staff around when required, if there are people who need assistance with eating for instance."

There were mixed views from people using the service about whether there were sufficient staff numbers to meet people's needs. One person told us there were "Not enough staff" and that they expected staff to be "on-call", but that it could sometimes be 10-15 minutes before staff could help them. Others told us, "There's definitely not enough [staff]" and "Everything is done in a rush; early morning it's a mad house." Other comments included, "Sometimes they do respond quickly to call bells, sometimes they don't… it's the luck of the draw." However, others told us, "There are enough staff" and "I have a call bell and the response is quite good." Another person told us, "It's better than it has been. They got new management in January and since then they have employed more carers." They indicated there were still "good and bad days" though, particularly on a weekend.

Comments from visitors were again mixed. One visitor we spoke with did not feel there were sufficient staff on duty. However, others visitors did not raise any concerns about staffing levels and one told us, "There always seem to be enough staff around."

On the first day of our inspection there were three nurses; one working on each floor of the home, plus a further nurse who was additional to the core rota, working on care files and clinical administration tasks.

There were ten care staff in the morning, plus an additional care staff member who was new, so was shadowing other care staff on shift. The atmosphere in the home was calm and staff did not appear hurried. We observed staff responding promptly to call bells. We looked at rotas for the last four weeks and these showed that there were generally three nurses during the day, and ten care staff from 7.30am to 1.30pm, reducing to seven care staff from 1.30pm to 7.30pm. There were some occasions where there was one care staff less due to staff sickness. On a night there were two nurses and generally four or sometimes three care staff. We saw that regular bank staff were used, plus agency staff where required, to ensure there were sufficient staff available to cover the rota. We looked at the registered provider's dependency level assessment tool, which was used to assess the level of staffing required in relation to the needs of people living at the home. This showed us that current staffing levels were in line with the requirements indicated in the registered provider's assessment.

The registered provider employed a range of ancillary staff, such as housekeepers, laundry, maintenance, kitchen and activities staff, which meant that nurses and care staff could concentrate on the delivery of care to people.

This showed us that the registered provider had a system in place for ensuring there were sufficient numbers of staff to keep people safe and meet their needs.

We looked at systems in place to ensure people received their medication safely. The registered provider had a medication policy. We saw that staff responsible for the administration of medication had received training in medication management and were assessed for their medication competency. One staff member told us, "The medication competency checks are very thorough. You have to answer lots of questions…you have to be observed doing a drugs round."

People's care files contained a care plan with details of any support required with medication. We saw these were detailed and reviewed each month, to ensure they were reflective of people's current needs. We looked at a selection of Medication Administration Record (MAR) charts. We found that these were appropriately completed, to show that people had received their medication as prescribed. We checked the stock balance for a number of medications and the stock held tallied with the stock level recorded on the MARs. There were protocols in place for people who were prescribed medication for use 'when required'; these protocols gave clear instruction to staff when and why the person may require this medication and records were completed when people received them. We also checked the provider's policy and records in relation to 'homely remedies'. Homely remedies are medicines that can be purchased without a prescription, such as paracetamol, for occasional use. The registered provider held an appropriate stock of homely remedies that was in line with the recommendations of the local clinical commissioning group. Use of these medicines was accurately recorded. There were also appropriately completed topical administration records for people who required prescribed creams.

Medication was appropriately stored. We saw that fridge temperature checks were recorded every night to ensure that medicines stored in the fridge were safe to use. Some prescription drugs are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled drugs and there are strict legal controls to govern how they are prescribed, stored and administered. We found that controlled drugs were stored correctly within suitable cabinets in the medication rooms, and that controlled drugs records were accurately completed.

We also observed medication being administered and spoke to staff about various aspects of medication management, including medication audits and the safe disposal of medication. Staff demonstrated a good level of understanding. The registered provider's policy was for comprehensive medication audits to be

completed six-monthly as a minimum, but the registered manager told us that they were completing these monthly at the time of our inspection because they recognised that they had had a number of new staff in recent months and were also using some agency staff, so they wanted to ensure extra vigilance in the management of medication.

This all showed us that there were systems in place to ensure people received their medication safely.

Good

Is the service effective?

Our findings

We asked people using the service if staff had the right skills and experience to do the job; people told us, "They have the right skill and experience," and "The girls are first class… no complaints." Others told us, "I am sure they are doing everything adequately" and "They are very good." One person however, told us that with new staff "You always have to prompt them along the way." A visitor told us staff were "Attentive and knowledgeable; they seem to have the right skills."

We spoke to the training co-ordinator and saw records that showed us that all staff completed an induction when they started in post. Staff completed training on the first three days of their induction programme and then shadowed other care staff for at least one week, sometimes two weeks, depending on when they felt ready to work independently. The induction training covered topics such as; fire, infection prevention and control, moving and handling, safeguarding vulnerable adults, Mental Capacity Act and Deprivation of Liberty Safeguards and duty of candour. Staff also completed a variety of other training via e-learning, such as food safety, allergens, fire, customer care and health and safety. The registered provider's induction programme had been cross referenced to ensure it covered the requirements of the Care Certificate. The Care Certificate is a set of standards that social care and health workers work to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. Nurses also completed a role specific induction booklet in addition to this.

Staff completed refresher training annually where this was required. The registered provider and training co-ordinator were able to monitor when staff were due to complete refresher training, as records were held electronically. The registered provider also had a training plan detailing the training available in the forthcoming year. The training co-ordinator told us that they issued reminders to staff when training was due. Staff told us, "Everything you need to do you are trained for. They send out a lot of reminders for training you need to do." Bank staff also confirmed that they received the same training and medication competency checks as regular staff; one told us, "The training is good and I definitely feel supported. Because I only work a couple of days a week the trainer will also email me with the dates of my training so that I get them straightaway." We looked at training records and these showed that the majority of staff were up to date with their training. We noted that some staff were overdue their annual refresher training. The training co-ordinator told us that reminders had been issued to relevant staff regarding overdue training, with the obligation that they must attend training as a core expectation of their role.

We saw evidence of staff supervision and team meetings; both covering a range of appropriate topics. Not all staff had experienced an individual supervision recently, as some supervision was done on a group basis. The registered manager told us that they intended to move towards a focus on individual supervision meetings and that they and the deputy manager had established a supervision structure. Supervision meeting dates were recorded on the training matrix, so it was easy to identify who required supervision. We also saw evidence of daily 'stand up meetings' where staff from each department exchanged key information, including issues relating to people, staff, activities or events taking place that day, new admissions and any accidents or incidents. This all showed us that people received care from staff that had the knowledge and support they needed to carry out their roles.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make 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 process for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the registered provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care files contained mental capacity assessments, and where relevant, information regarding DoLS authorisations that were in place. We saw evidence in care files that people had been involved in decisions about their care, where they had the capacity to do so. There was also evidence that where people lacked capacity to make a particular decision, a decision had been made on their behalf in their best interests, involving professionals and family members.

Staff had completed MCA training. They were also able to demonstrate an understanding of the principles of the MCA, and the importance of gaining consent before providing care to someone. This showed us that staff sought consent to provide care in line with legislation and guidance.

We looked at the support people received with their nutritional needs. Care files contained a section about people's nutritional needs, including information about the type of diet required, food preferences and any adapted crockery or cutlery required. We saw that where relevant, input and advice from specialists, such as speech and language therapists, had been obtained for people. Nutritional intake was recorded for people assessed at high risk due to their nutritional needs or weight loss. The registered manager completed a nutritional report each month which was to monitor people who had lost weight or were at high risk of malnutrition.

There were mixed views about the variety and quality of the food available at the home. Some people using the service told us, "On the whole the food is pretty good. It's a wonderful menu, you can more or less have three full meals if you want them," "The food is good" and "The food is average; you do get a choice." Another told us "The food varies. On average it's not too bad; there's enough variety, and there's fruit and veg." One person told us, "There are two alternatives every day. It is served hot and there is enough to eat. We have coffee and afternoon tea, fruit and biscuits." However, they also told us they didn't like the food every day. One person who was dissatisfied with the food said, "There is a lack of variety and quality; loads of mince and sausages but in different forms… It's served hot, but there's too much."

Feedback from visitors was also mixed. One visitor told us, "The food looks good and [Name] seems to enjoy it. They've put on weight since coming here. [Name] likes their food piping hot – they've always liked it that way – and the staff accommodate that for them, because it's really important to them." Another visitor said, "[Name] likes the food very much." One visitor told us, "The food is good. [Name] is always saying how much they enjoy it." However, they also went on to express concern that because the staff encourage their relative to be independent and eat themselves, they were concerned whether their relative had sufficient support with eating, and felt it was undignified if food was left on a tray in front of them that they could not manage very well. Another visitor also raised concern about whether their relative, who was cared for in bed, got sufficient support to eat. They were not confident whether staff always went back to offer food again, if their relative was asleep when the food was first offered.

We spoke to the registered manager about this who told us that staff were aware who required assistance with eating and that staff should always return to offer food again if someone is asleep. They issued a reminder to staff about this in a team meeting after the first day of our inspection and told us that they would monitor this to ensure that all people were getting sufficient assistance with their meals.

We observed two mealtimes at the home and saw that people could eat in the dining room or in their own bedroom if they preferred. There was a quiet, relaxed atmosphere in the dining room and tables were laid with cloths, wine glasses and condiments. People were shown the menu and offered a choice from the two main options available. People were offered a choice of drinks, including water, wine or lemonade. The food looked hot and appetising. People were also offered additional helpings of food and drinks. We observed people eating independently in their own rooms, and staff were available to assist where required.

Facilities to make drinks were available on each floor for visitors and people who used the service. Drinks were also offered to people, including those who were in their bedrooms, throughout the inspection.

When we spoke to the chef about people's special dietary requirements, they were knowledgeable about people's needs and preferences. They had a copy of each person's food likes and dislikes, and an up to date list of people's dietary requirements. They were also able to explain how they catered for individual needs. There was a four week menu cycle, and in addition the home had recently introduced a 'favourite of the day' option on the menu once a month; this was a favourite meal chosen by a different person each time. The chef told us that the home had established a food forum in response to feedback from some residents, to engage people using the service in making suggestions about food they would like to see on the menu. They told us about things that had been changed as a result of the forum, such as having separate gravy boats, making sure people were aware of additional sauces and jams that were available and the introduction of new breakfast options. They told us the food forum would continue to meet so that people could have further opportunity to give feedback and make suggestions about the food available at the home. The registered provider had also held a 'Nutrition Tea Party' in March 2016, raising awareness of nutritional issues and modified and fortified diets.

This showed us that people were supported with their nutritional needs.

People were supported to maintain good health and access healthcare services. We saw evidence in care files that people had received support from other healthcare professionals where required, such as GPs, speech and language therapists, psychiatrists and opticians. There were also instructions in care files where people needed specific assistance to maintain good health, such as support with catheter care or pressure care.

Good

Is the service caring?

Our findings

We asked people using the service if staff were caring; the majority of the feedback we received was positive. People told us, "The staff are caring" and "Yes they are caring; they are good fun." Others told us "They are very caring; they make jokes and try to make you laugh" and "They [staff] are all lovely; they do a special job and are never miserable. I can't speak highly enough of the staff." One person however, told us, "They do talk across me quite a lot. They are not lacking on the care; they put your socks on etcetera, but they are talking across to each other and don't listen to me." We raised this with the manager who said they had recently discussed this issue in a team meeting, because this had been raised before and was not acceptable, or respectful, practice. We saw from staff meeting minutes that the registered manager had been clear in their expectations of staff about the standard of care and respect required. The registered manager told us they would continue to monitor this and take action if any staff were observed doing this.

Another person told us that changes in staff affected them, because "I get used to them and they get used to me. I need to feel confident in staff." They continued, "Continuity [of staffing] is improving though. They introduce new carers and they do shadow shifts to watch experienced carers. Up to now the new carers they've employed are very good."

Visitors told us, "The staff are kind and caring" and "They [staff] are really nice, and do a good job. There are two staff in particular who [Name] really loves; they are really nice and pop in for chats with them." Another relative told us, "Staff seem caring and kind."

Staff we spoke with demonstrated a caring approach towards the people they supported. One told us, "The staff all want to be here, they are willing to help the residents and go the extra mile." We observed staff supporting people throughout our inspection, and interactions were positive and friendly.

We observed staff offering choices and responding to requests from people. Staff were able to describe how they offered people choice, and gave specific examples of how they showed and explained options to people, and came back to people again where needed, in order to re-iterate options and give support with decision making. It was evident from people's care files that people had been involved in decisions about their care, where they were able to do so. Monthly care profile reviews included questions about people's views on what was good about living at the home that month and whether there was anything staff needed to change. Where people were unable to express their wishes and views verbally, this was completed using staff observations. Care files also gave instructions to staff on how to promote people's independence wherever possible; for example, one person's care file included specific instruction to staff about how the person was able to wash the upper half of their body themselves, but required the support of one staff member to wash the lower half of their body. Comments from people using the service included, "I am supported to be independent."

Discussion with staff indicated that there were no people using the service that had any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. Most people using the service could potentially be at

risk of discrimination due to age or disability, but we saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. Care files contained a section in relation to cultural, spiritual and social values.

People told us that staff maintained their privacy and dignity, especially when providing support with personal care, such as bathing and washing. People told us, "They are pretty good" [at promoting privacy and dignity]" and "They respect my privacy." One person told us "Some [staff] are very particular and make sure you're covered up" but they suggested that this was not always consistent. Throughout our inspection we saw that staff always knocked on people's bedroom doors before entering and were respectful when addressing, or discussing people using the service. Staff we spoke with understood the importance of respecting people's privacy and dignity and were able to explain how they put this in to practice. They gave examples such as ensuring people's door and curtains were closed when providing support and ensuring people were covered with a dressing gown or towel. They told us, "Staff treat people as they would want to be treated."

Visitors we spoke with told us they were able to visit any time, and were made to feel welcome.

Good

Is the service responsive?

Our findings

All of the people using the service had a care plan, and there was evidence that people had been involved in developing and reviewing these, where they had the capacity to do so.

The registered provider completed an assessment of people's needs, prior to supporting them, to ensure the service could meet their needs. This assessment covered areas such as; communication needs, personal hygiene and dressing, continence, mobility, moving and handling, tissue viability, nutrition and hydration, breathing, pain, sleeping, mental state and cognition, gender sexuality and relationships, hopes and concerns for the future, social interests and spiritual or cultural needs.

This assessment then formed the basis of the care plan, which was developed when people moved to Mulberry Court. Files included care plans in relation to each of the areas in the assessment. We found care plans were detailed and person centred. There was comprehensive information about people's needs, the support required from staff, and people's individual preferences. For example, we saw examples of clear instructions to staff about preferences in relation to people's personal care needs. There were also very clear instructions to staff about one person's preferred routine, where the importance of a fixed routine was very important to that person. This meant that staff had the information they needed to provide personalised care to people.

Twice daily entries were made in each person's progress notes, to monitor any issues or changes. Monitoring records in relation to specific issues, such as food and fluid intake and re-positioning, were also in place for people who were assessed as requiring them. We found these were generally well completed. This enabled the registered provider to monitor that the care delivered was in accordance with the identified need in the person's care plan. It also meant they were able to monitor that strategies used to respond to risk areas were being effective.

When we spoke to staff they were knowledgeable about people's needs. Staff also told us how they got to know people and their life history, when they first moved to the home.

People were involved in reviews of their care plans and we could see from the records held that care plans were reviewed monthly and updated where required. There was also a more comprehensive review of each person's care every six months, involving relatives or representatives where applicable. Three out of the four care files we reviewed were up to date at the time of our inspection, but one was slightly overdue, according to the registered provider's policy to review care plans monthly. We spoke to staff about this, and they agreed to review it that day.

The registered provider employed two dedicated activities co-ordinators and activities were provided every day. We spoke to an activities co-ordinator who told us that the activities calendar for the coming week was prepared each Sunday, and we saw that the calendar of activities was displayed in a number of places in the home, including the corridors and lift. There was an activities room on the first floor of the home. On the first day of our inspection the activity taking place in the morning was dominoes and in the afternoon there was

an entertainer singing war time songs, which people attending appeared to enjoy.

The registered provider conducted a quarterly activities forum with residents, so that people could make suggestions about activities they were interested in. The activities co-ordinator told us that they also provided individual support to residents who could not access activities due to being cared for in bed; this included manicures, reading to people, and chatting for companionship. The home had shared access to a minibus with another local home in the area, which was owned by the same registered provider. This minibus was used to take people on trips out; recent trips had included visiting a local air museum, a meal out and a retail shopping outlet. Students from a local school also visited people using the service.

The registered manager told us that some people using the service were interested in gardening, and so this year the home was going to be working with people using the service to take part in the registered provider's 'garden of the year' competition.

The activities coordinator completed activities logs, to record when people had participated in activities and what they had enjoyed. This enabled the registered provider to monitor the activities and stimulation that people were receiving. Some people we spoke with told us they did not always join in the activities, but they were aware they were available should they wish to participate. One person using the service told us, "The activities team are very supportive."

This showed us that people received personalised care that was responsive to their needs and there were a range of activities available to people.

There was a complaints procedure in place and a system to record and respond to complaints. The complaints procedure was available to people who used the service, and we saw from minutes of a resident's meeting in February 2016 that people were also encouraged to raise any concerns in those meetings. Records showed that one complaint had been received in the year prior to our inspection, and four compliments received. The provider had responded to the complaint within 28 days, to investigate and address the issues raised.

People we spoke with told us they knew how to raise a complaint. However, one person told us, "They brush it under the carpet if you want to complain." Others did not share this view and told us, "I'd know how to make a complaint if I needed to, but haven't had to…I'm very happy with the care here."

We saw from minutes of residents meetings, food and activities forums, as well as monthly care evaluations and six-monthly care reviews, that people had opportunity to share their views about their care and issues at the home, and that the registered provider was acting on this information. One person using the service told us, "You can go to meetings to voice your opinions." The registered provider had also started to involve people using the service in staff recruitment interviews, in order to give people more choice in relation to staffing decisions. This was in its early stages, but the deputy manager told us they were using the learning from the first couple of times they had tried it to improve the process for the future, and establish the practice more routinely.

This showed us that people's views and opinions were encouraged and that there was a system in place to respond to complaints.

Good

Is the service well-led?

Our findings

The service had a registered manager who had commenced in post about four months prior to our inspection. The registered manager understood their role and responsibilities, and told us they had a focus on continual improvement for the service. There was also a deputy manager for the service, who provided clinical leadership to the nursing team.

When we spoke with people about the management of the service the feedback was generally very positive. One person using the service told us, "If I want to see [registered manager] they will come up and talk to me." Another person however, told us that they did not know who the management were. Comments from staff included, "[Registered manager] and [deputy manager] are very approachable. If you need anything they would be willing to help you," "[Registered manager] is very good; very supportive and friendly" and "There is really good support, a nurse is always there if you need to talk." Other staff told us, "The home is well led and well organised; improvements have been made, such as the 'resident of the day' scheme. [Registered manager]'s door is always open and you can go and see them" and "Mulberry Court is now well led. [Registered manager] is putting in a lot of time and effort and wants us to be one team. [Registered manager] is always pleasant and polite and seems to be getting things done."

The registered manager told us they kept up to date with best practice and legislation via updates from the registered provider, the independent care group and management meetings. Key information about best practice and any changes in legislation was shared with staff in team meetings.

We looked at evidence of team meeting and nurses meeting minutes and saw that topics discussed included reminders about practice issues and record keeping, expectations of staff, team working, audits and communication. The registered manager told us, in their provider information return, that they were increasing the frequency of team meetings to improve communication at the home.

The registered provider conducted annual satisfaction surveys. Responses to surveys were collated and action taken to address issues arising from these. For instance, in the most recent survey some respondents indicated that they were not aware they could be involved in their relative's care plan reviews. In response, the registered manager had reminded relatives about this, and had established a new relative's forum in order to engage more with relatives of people using the service. The registered provider had also conducted a survey with relatives about what activities they thought their relative may enjoy.

The registered provider had information about the aims and objectives of the service in their Statement of Purpose. Their mission statement described the values of the service. Comments from staff showed us that the service promoted a positive and person-centred culture.

The service had systems in place to audit the quality of the care they provided to people. As well as the satisfaction surveys conducted, the registered provider completed a range of audits. These included audits in relation to medication, care plan reviews, accidents and incidents and monthly nutritional reports. We saw these audits were regularly completed. The registered manager was required to enter a range of

information from audits on to the registered provider's electronic clinical governance system each month, so that patterns could be analysed and checks conducted in order to ensure appropriate responsive action was being taken with regard to any issues.

The regional director completed quarterly 'Quality First' audits, and the registered provider's nurse development team conducted clinical audits. In addition, the registered provider had an internal regulation team that conducted periodic unannounced visits to the home to evaluate practice in relation to regulatory standards. We saw that recommendations from these visits had led to improvements being made, such as replacing hoist slings.

This showed us that systems were in place to monitor and review the delivery of care and the quality of service that people received.

Policies and procedures were in place, and based on up to date legislation and guidance. We asked for a variety of records and documents during our inspection. Overall we found these were well kept, easily accessible and stored securely.