Mulberry Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

We inspected the home on 28 and 30 October 2014. This was an unannounced inspection.

Mulberry Care Limited is a care home without nursing that provides services for up to 35 people with dementia. The home has two wings, east and west. At the time of our inspection 32 people were using the service.

A registered manager was employed by this service. 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's safety was compromised in the home. The premises and some equipment were not cleaned or well maintained. Procedures to control the spread of infection were not robust. There was ineffective support for people who became distressed or who were unable to make their needs known.

Summary of findings

Changes to people's care needs were not always well recorded. In some cases this put people at risk or meant they were not having their individual care needs met. People had sufficient to eat and drink to meet their nutrition and hydration needs, however support from staff at meal times was inconsistent. People had access to health care professionals which helped them to stay healthy.

We observed kind and friendly interactions with staff. People and relatives made positive comments about the staff and the care they provided. However, we observed people's dignity was not always respected and their privacy was not always maintained. There was an activities programme, however opportunities for social engagement were limited and some people living at the home were not engaged in meaningful activities.

The registered manager had a system to assess staffing levels and make changes when people's needs changed. People told us they thought there were enough staff and that they did not have to wait for staff to support them. We saw that calls bells were answered quickly. Relatives told us there weren't always enough staff to support people with activities.

Staff training records indicated which training was considered mandatory by the provider. Not all staff were up to date with, or had received their mandatory training. We saw evidence that learning was not always put into practice when staff supported people. The provider and the registered manager could not be sure staff had the appropriate knowledge and qualifications to meet people's needs at all times.

Staff said they felt supported to do their job and could ask for help when needed. They received regular supervision and had opportunities to discuss any matters in the team meetings. Staff were able to obtain further professional development such as National Vocational Qualifications (NVQ) or Qualifications and Credit Framework (QCF) awards and some were in the process of achieving them.

Relatives felt their family members were kept safe and were satisfied with the care and support provided. Care staff knew how to identify potential abuse and understood their reporting responsibilities in line with the service's safeguarding policy.

Staff followed the principles of the Mental Capacity Act 2005 (MCA) when supporting people who lacked capacity to make decisions. The manager had knowledge about Deprivation of Liberty Safeguards (DoLS) and MCA. They had taken appropriate action with the local authority to ensure where restrictions were placed on people, these were reviewed and agreed. Where people's liberty was restricted, this was carried out in the least restrictive way in order to help protect people's rights and freedom.

The registered manager had a system in place to assess and monitor the quality of care. The registered manager investigated and responded to people's complaints, according to the provider's complaints procedure. Annual questionnaires were sent so people and relatives could share their views. However, the quality monitoring system did not effectively identify all issues or concerns with the home and practices. Without an effective system the home was not able to make improvements where and when necessary so that people could receive the support and care they needed.

The registered manager did not always take proper steps to ensure people were protected against the risks of receiving unsafe or inappropriate care or treatment. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report. We also made a recommendation to review guidance on making the environment more 'dementia friendly'.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe. People were at risk because premises and equipment were not managed well to keep people safe. Cleanliness and hygiene standards had not been maintained at all times to prevent cross infection. Medicines management was not always safe or in line with people's needs.

The provider's recruitment processes were not robust. There were enough staff on duty to meet people's basic needs. However, the organisation of the staff did not allow them to spend time engaging with people.

Staff knew how to identify the signs of abuse and knew the correct procedures to follow if they thought someone was being abused.

Is the service effective?

Requires Improvement

The service was not effective. People's needs were not always met because staff did not always follow the care plans. Staff received supervision and said they were supported to carry out their jobs. However, they did not always receive the required training that would enable them to meet people's needs effectively. Staff did not always have the knowledge they needed to support people in stressful situations.

People had sufficient to eat and drink but they gave mixed comments about the home's food and mealtime experience.

The manager had knowledge about Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). They had taken appropriate action with the local authority to make sure people's rights and freedom was safeguarded. People who may not be able to speak up for themselves had access to advocacy services to represent them if needed.

Is the service caring?

Requires Improvement

The service was not always caring. Relatives and people were positive about the staff and the care they received. However this was not always supported by our observations. People were not always supported with care, respect and dignity.

Visitors were welcomed and people were able to maintain relationships important to them. People, and those that mattered to them, could make their views known about care and treatment and concerns were addressed.

Summary of findings

Is the service responsive?

Requires Improvement 

The staff were not always responsive to people's needs. People's individual needs were not supported at all times. Care plans did not always show the most up-to-date and important information on people's needs, care and welfare. Staff did not always interact with people or respond appropriately to people if they became distressed.

The service managed complaints that had been raised. Relatives and staff told us they knew how to make a complaint or raise a concern.

There was an activities program. However, there were not enough meaningful activities for people to participate in as groups or individuals to meet their social needs.

Is the service well-led?

Inadequate 

The home was not always well led. People were put at risk because systems for monitoring the quality of the service and risks were not effective.

Monthly audits were not carried out on a regular basis. Problems with the service and required improvements were not always identified and this had an impact on people. We did not always see evidence of action plans or action taken where a concern had been highlighted.

The manager was available to people, relatives and staff and they had opportunities to discuss various topics and raise concerns. They felt the manager listened to them and took action to address any concerns.

Mulberry Care Ltd

Detailed findings

Background to this inspection

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

We visited the home on 28 and 30 October 2014 and this inspection was unannounced. During the visit, we spoke with eight people living at Mulberry Care home, eight relatives, eight care staff, and the registered manager. We observed how people were cared for and supported. We looked around the home and at a range of records about people's care and how the home was managed. This included four people's activity folders, 12 care plan files, 10 recruitment files, support and supervision records , training matrix, health and safety records, internal audits, a Boots medicines management audit, incident and accident folders, safeguarding log, complaints and compliments log.

The inspection team consisted of two inspectors, a specialist nursing advisor 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 service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before the visit to the home we looked at previous inspection reports and notifications that we had received. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR was information given to us by the registered manager. This enabled us to ensure we were addressing potential areas of concern and identifying areas of good practice. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted commissioners of this service in the home to obtain their views.

Inadequate

Is the service safe?

Our findings

At our inspection in May 2014, we were concerned about the recruitment and selection process, consent to care and staffing levels. We asked the registered manager to send us an action plan outlining how they would make improvements. At this inspection, we found that some improvements had been made, but there were still some concerns remaining.

At the last inspection we found gaps in employment history without written explanation. At this inspection we reviewed 5 recruitment and employment files of staff who had been employed since May 2014. Some information had been obtained to explore employment history gaps. However, some information was missing. In one file for example a three year gap in work history was evident. There was no DBS (Disclosure and barring Scheme) check in one file. A DBS certificate check allows employers to check if an applicant has any criminal convictions that may prevent them working with vulnerable people. There were no health checks in an additional three files. The registered manager did not always follow an effective recruitment and selection procedures to ensure people were not placed at risk of being cared for by unfit and inappropriate staff.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the medicines management in the home. We observed the administration of medicines during lunch time. The administration and storage of medicines was unsafe. There was no dedicated person who was responsible for the administration of the medicines. We saw that medicines were left unattended on the lunchtime trays which were waiting to be delivered to people in their rooms. We also saw staff members carrying several pots of unlabelled medicines. This could increase the risk of staff giving the medicines to the wrong person. The Medication Administration Record (MAR) sheets were not signed after medicines were given. This is needed to confirm that a person had taken their medicine at the prescribed time and to reduce the risk of drug errors. If people were not ready or refused to take their medicines these were placed in a cupboard in the dining room to be taken later. This cupboard was not locked or secure.

We observed how people were supported to take their medicines. Staff were helpful and did not rush people. However, we did not observe correct administration of medicines. Some people were given medicine with a spoon one tablet at a time. Other people had their medicine by taking it from staff's hands who were wearing gloves. The gloves were not changed between assisting individuals. This could increase the risk of the spread of infection. We reviewed people's care plans for details of how staff should support people to take their medicine but we could not find any record relating to these types of arrangements. Not all staff who administered medicines had been trained.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We told the registered manager of our concerns regarding the administration of medicines. On the second day of inspection, they told us this had been addressed with staff. We observed the medicines administration round again, staff gave medicines and signed the sheets immediately afterwards. They were observed by the registered manager to ensure they were carrying out the task correctly.

People were not always protected from the risk of infection because not all areas of the home were kept clean and cleaning was not effective. Some equipment and furniture was dirty and not cleaned properly. For example, two cushion in the lounge. Some bathrooms and areas of the home were dusty and had mould and grime present. For example, at the base of the shower door and wash basin. The cleaning schedules we looked at showed all of these areas had been cleaned. We observed that wet mops were not stored correctly increasing the risk of cross infection.

We saw that staff wore gloves and aprons throughout lunch time. They handled food, medicines and equipment as well as supporting people with mealtimes and assisting people to use the toilet. However, we did not observe any staff changing their gloves once they finished with one task and before they carried on with another one. We raised this with the registered manager on the first day of our inspection. On the second day of inspection, we observed staff were still wearing gloves in between assisting and supporting people. This increases the risk of cross infection and is not in line with the Code of practise for Health and Adult Social Care on the Prevention and control of infections and related guidance.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service safe?

We walked around the home to observe the environment and layout of the home. There was a bathroom upstairs that had a wide open window. According to the home's risk assessment, all windows had to have restrictors. There was a risk of people falling out through the window as no safety measures were in place.

Staff were not always using signs to indicate a slippery surface. We saw that the stairs and floor in the hallway had been cleaned. These were still damp and therefore slippery. This posed a risk of falls or slips to visitors and people. We asked for the sign to be put up, this was responded to.

There were small areas of flooring in the home which were raised and broken, providing a potential trip hazard. We noted this to registered manager who assured these issues would be addressed straight away.

At our last inspection there were not sufficient staff to meet people's needs. At this inspection we looked at the current staffing levels. The registered manager used a system to assess people's needs and calculate appropriate staffing levels. The registered manager had staffed the home according to assessed needs. We noted that call bells were answered quickly and we did not observe people having to wait to get support from staff.

The manager told us they had employed two extra staff to support people at mealtimes. However during lunchtime, we saw people sitting in the dining room, their own rooms or the lounge. People eating in the lounge and their own rooms had to wait to be served after those being served in the dining room. Some people in the lounge were not happy with the waiting time which did not make the meal time a pleasurable or social experience for them.

We looked at people's care records and saw that routine risk assessments were carried out. For example, risk assessments related to safe use of bed rails, mobility and nutrition. However, some care records did not have clear guidance on support people needed to reduce risks specific to individuals. For example, one person was at risk of falling out of their wheelchair when reaching for things. Another person enjoyed making a drink for themselves and others. There were no risk assessments completed to ensure that appropriate support was identified so they remained safe while maintaining their independence.

Relatives felt their family members were kept safe and were satisfied with the care they received. Care staff knew how to identify potential abuse and understood their reporting responsibilities in line with the service's safeguarding policy. Staff were familiar with the whistle blowing policy and knew who to go to in order to raise a concern. Some staff told us they were not sure if there was someone else they could report their concerns to outside of the service. We were aware of ongoing safeguarding cases and noted the provider was working together with local authority to address them.

Requires Improvement

Is the service effective?

Our findings

People's needs were not always met because staff did not always receive appropriate training on time to be able to fulfil their roles. The latest training matrix showed that not all staff had completed the necessary training updates considered mandatory by the provider. For example, fire safety and administration of medicines training updates are required yearly by the provider's mandatory training policy. Three care staff had not completed a fire safety update since December 2012 and nine care staff had not completed their medicines training update since January 2013. This was evident in the standard of care we observed.

The provider had determined care staff had to update challenging behaviour training every three years. From the training matrix we saw the majority of staff had either completed or were undergoing the training provided. However, we did not always see staff responding to people's individual needs effectively. For example, one person became distressed and showed behaviour that challenged others around them. Staff did not approach the person and support them to calm down. The registered manager had to help staff reduce the anxiety of the person and ensure other people were not affected by this situation. During the rest of the day the same person became anxious on a further two occasions. The support and reassurance given by staff was either not very effective or not given at all. The person's care plan had coping strategy guidance for staff when the person was distressed. We did not observe this guidance being followed.

Staff did not always use safe moving and handling techniques. Two staff members helped a person to stand up and transfer from the chair to the wheelchair. One staff member helped the person to stand up by holding onto the top of their skirt and tights. Although the person and staff talked through the process of transfer, this was not a safe way to help someone transfer. The training they had received had not been effective. Staff had not followed their training or the moving and handling guidance for this person as detailed in their care plan.

People were at risk of receiving ineffective care and not being adequately supported because staff did not always receive effective training and professional development.

This was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We talked to people and relatives about the food and drinks at the service and observed the mealtimes. There were arrangements in place to cater for different people's needs, for example, diabetes or according to a person's culture. We received a mixture of views regarding the quality of the meals people received. The relatives thought the food was fine and people looked well and healthy. People said: "Lunch was ok", "The meals are not very good today" and "Lunch was quite good today". People also told us: "The lunch is not bad but no one comes in to sit with me much" and "there is a choice for lunch most days".

People were not always offered a choice of how the meal would be served. For example, people were given lunch with gravy rather than asking them if they wanted gravy on their meal. We also saw that on the day of our inspection dinner consisted of beans, fried eggs and hash browns. People were only offered spoons as cutlery. Not everyone could manage well to eat their dinner with the spoon but staff did not offer any other cutlery.

There were a number of people in the home living with dementia. Research has shown that signage for people with dementia can be a very effective memory aid when used in buildings where people with dementia or memory loss live. Signs around the home can help reduce confusion and help with daily orientation. There was no dementia signage used in the home. The registered manager was aware the home was not dementia friendly. They told us they had some plans to put dementia pictures and signs in the home.

We recommend the service explores all relevant guidance on how to make environments used by people with dementia more dementia friendly.

At the last inspection, we found some concerns regarding consent to care and the requirements the provider had to meet in order to make sure people were supported and cared for in a lawful way. At this inspection, we found the home to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The DoLS provide a lawful way to deprive someone of their liberty, provided it is in their best interests or is necessary to keep them from harm. The registered manager had also taken action to improve their knowledge and understanding of the Mental Capacity Act 2005 (MCA). This legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves.

Requires Improvement

Is the service effective?

Each person had been reviewed to determine which decisions they could make and when they required support with this. We looked at records of best interest meetings held with the person and those important to them discussing the best care and support for the person when appropriate. Staff had a good general understanding of what mental capacity meant. They understood it was important for people to be able to make decisions and have choices. Staff were able to help people make decisions if needed. If they had any questions about the mental capacity of a person, this would be discussed with others to ensure decisions were made in people's best interest.

We observed some good practice in supporting people. During our inspection a gentleman was supported to get up from his chair and transfer to the wheelchair. Two staff were using transfer aids appropriately. The person was talked through the process ensuring he was comfortable. The person was chatting to staff and the process was carried out with sensitivity. People told us: "It's my home and I am pleased they treat it as such" and "They are very good staff and they work well as a team. Relatives were complimentary of the support and care provided: "Staff are always welcoming and I get on well with all of them" and "Staff are very helpful, pleasant and willing to help".

People were referred to other healthcare agencies and so received comprehensive care, treatment and support in a timely manner. The registered manager worked with other professionals to request assessments, for example an occupational therapist for equipment or district nurses. Relatives told us if they had any real concerns about health issues they would speak to the registered manager and staff. They also told us they were always informed if their family member was not well. People had regular access to healthcare professionals, such as GPs, physiotherapists, chiropodists, opticians and dentists and had attended regular appointments about their health needs.

We spoke with staff about the support they received. They said they felt supported to do their job and could ask for help when needed. There was evidence that staff received regular supervision. Staff were able to obtain further professional development such as National Vocational Qualifications (NVQ) or Qualifications and Credit Framework (QCF) awards and some were in the process of achieving them.

We contacted service commissioners for their views. They were working with the provider to address ongoing issues at the home. There was an action plan in place to address areas of concerns and carry out improvements in a timely manner to ensure people received safe and well-coordinated care and support.

Requires Improvement

Is the service caring?

Our findings

People were not always cared for, supported and listened to in a consistent way which could impact on their individual needs and wellbeing. There was a risk of people receiving inappropriate care or support because staff did not always focus on people's welfare. We also observed people who found it difficult to initiate contact were given little time and attention throughout the day. Two people said: "It is not my home really and I only get a few visits from staff" and "I am not very keen [being here] and there is a lack of coordination [amongst the staff]".

Although we saw some good interactions between people and staff, we also saw that people were not always supported in a caring way. Staff did not always recognise when some people became agitated or distressed and did not treat them in a caring manner. During our inspection some people did not get any attention from the staff. We observed situations where people's behaviour was not managed well by staff. For example, during lunch and dinner time two people were clearly not enjoying each other's company. Staff did not recognise this and did not come to reassure them or find out if there was somewhere else the people would prefer to sit. The meal time experience was not pleasurable for either person.

We observed a mixture of interactions between staff and people they were assisting with their meals. When people were supported to eat their meals, this was done in a caring way. Staff chatted with people, held their hand and did not rush the meal. Staff read body language well when the person was ready to eat some food or have a drink. However, we also saw staff would occasionally leave people requiring help with their meals to carry out a different task. There was no consistency with helping people eat. Staff kept changing to support different people with their meals. Some staff assisted people to eat while standing and a few staff were helping others but could not support everyone in the room.

During both days we observed the lunch time activity. On the first day staff started cleaning and hoovering the floor while people were still eating. Some people were watching television but could not hear anything due to this. They were not asked if it was alright with them for staff to start cleaning. On the second day, domestic staff checked if it was alright to hoover. However, people were still eating and care staff had to ask them to wait until people were finished.

Although staff were caring and kind, they did not always treat people with respect or maintain their dignity. For example two staff members helped a person to transfer. Although the person and staff talked through the process they did not support the person correctly. Staff supported them in the transfer by holding onto the waist band of their skirt tights. This was not dignified. Another person asked for a wheelchair to help them move around which was responded to promptly. They went to use the toilet and were able to transfer onto the toilet seat without assistance. However due to the layout of the toilet, it was not possible for this person to use it independently and close the door to maintain their privacy and dignity. The window of the bathroom was not frosted and there were no curtains or blinds. It was easy to see into the bathroom and so people's privacy and dignity was not protected.

This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010.

We did observe staff interacting positively with people. They were helpful, reassuring and kind. People were asked for their agreement before staff supported them. Relatives knew some staff well. They told us staff were caring, kind and helpful, particularly some who were building very good relationships with people which had a positive effect on their wellbeing. One person was having their meal in front of the kitchen window. The person could observe what was going on in the kitchen, chat to staff or ask for help if they needed.

People were encouraged to make decisions and were given the appropriate level support. For example, a few people needed to move around the home. They were asked if help was required and staff responded accordingly. The registered manager told us advocacy services were available to people. They told us one person who lived in the home currently used one. An advocate is a person who represents and works with a person or group of people who may need support and encouragement to exercise their rights, in order to ensure their rights are upheld and correct procedures are followed. If someone needed to have an advocate, this would be discussed and the adult social care team at the local authority would be contacted to advise them which agency to use.

Requires Improvement

Is the service responsive?

Our findings

The home was not always responsive to people's needs and wishes. Each person had a support plan which was personal to them. These plans included information on maintaining people's health and wellbeing, their daily routines and how to support them appropriately. Staff had access to information which would enable them to provide support in line with the individual's wishes and preferences. However, care plans did not reflect that care and support was provided in accordance with people's individual preferences. Records were not always detailed, for example, "Activity done". There was little information about people's physical health or emotional wellbeing or how they spent their day. Important information could be missed and not communicated to staff, relatives and health/social care professionals because it was not recorded.

The provider had a system to record care plans and risk assessments for different needs including pressure area care, falls, personal safety and mobility. However, this was not always accurate or up-to-date to help staff provide people with appropriate care and support.

There was a program to engage people in activities, maintain their social skills and achieve emotional wellbeing. Activities were listed on display boards throughout the home. Activities included puzzles and card games, arts and crafts, quizzes, ball games and skittles. The hairdresser also visited the home once a week. However, the activities calendar was from April 2013 and so not current. We looked at activity forum records where people and staff discussed activities held. No further plans for future activities had been discussed. Relatives told us the staff were very kind and friendly and that activities were optional if people were not interested. However, they felt their family members were missing out on having quality time with the staff. They thought it was not always possible as other people needed more help or there was not enough time.

Even though the service had a programme of activities, some people were not protected from isolation and there was a lack of stimulation for them. People were not always helped to maintain their wellbeing or encouraged to participate in an activity suited to their needs. On the day of our inspection three people went out to the day centre for the whole day as a weekly activity. A few people went for a walk. However, most of the day people sat in the lounge watching television.

We looked at the care plan for a person who used to go out of the home for a walk. This person's needs had changed and they were no longer able to go out independently. There was no record of these changes and how staff could support this person to continue enjoying this activity.

People's likes, dislikes, preferences and history were included in their activity records to help identify an activity that would be meaningful to them. During our inspection we observed some people playing skittles and some ladies having their nails painted. However, these activities did not reflect people's recorded interests. In the west wing, three people were sitting in the corner of the lounge. It was dark therefore one person could not read their newspaper. No staff came to interact with them or turn on the lights. One person commented that: "I would like to go out. I would like to read but I do not get any newspaper". We saw there were newspapers in reception but this person was not offered any to read. They were in the same place for the whole day watching television. Staff did not encourage a people to use a past skill or engage in activities that were meaningful to them.

People's wishes to maintain relationships that mattered to them such as with family, community and other social links were respected and encouraged. Relatives were able to visit at any time and were always welcome to spend time with people. However, one relative felt the home could have a space for people and visitors to meet and have some privacy. Relatives were encouraged to support people to plan their care. The registered manager and staff were responsive to requests and suggestions. Relatives felt supported and involved in the lives of their family members who lived at the home.

The home had a complaints procedure which provided information for people about how to make a complaint. Relatives told us they had no issues with approaching staff and the registered manager about raising any concerns or issues. One complaint had been raised since our last inspection. This was investigated and addressed. We saw some compliments received from families thanking the

Requires Improvement

Is the service responsive?

home for the care and support provided to their relative. The lessons learned from complaints were shared among the team to make sure the issues identified did not happen again.

Annual questionnaires were used to seek the views of people, relatives and other stakeholders. People and relatives were encouraged to give feedback and share their experience and concerns. There was a resident's meeting held on a quarterly basis. Relatives told us they had an opportunity to share their views if they needed to and they were responded to appropriately.

Inadequate

Is the service well-led?

Our findings

The service was not always well led. People did not benefit from high quality, person centred care because the management of the service was not robust. The registered manager reviewed aspects of care and support in the home, for example, recruitment, training, medicines, activities and safeguarding. A quality management non-conformity report was completed. This detailed the issues, causes, actions to be taken and confirmation of completion. Comprehensive internal audits were scheduled monthly. However, the last audit carried out was in September 2014 and prior to that July 2014. The monitoring of the quality of the service was not effective. We found some identified but unaddressed issues during our inspection. The registered manager had a system in place to monitor the service however they had failed to carry out regular audits. The system was not effective and had not identified all concerns.

We reviewed systems the home used to assess and monitor the quality of the service that would ensure people's health, welfare and safety. We reviewed the Provider Information Return (PIR). This had identified some areas for improvement. However, other areas of the service also needed review and improvement. For example, responding to people's needs, making sure staff were using assessment tools correctly, maintaining a clean and safe environment and being involved in meaningful activities. The provider had policies and procedures available to give guidance to staff on how best to support people. However, the practice in the home did not always follow the policies and procedures

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager had a system to manage and review care plans and risk assessments, and other home management records. However, records were not always completed accurately or altered when necessary. For example, when people's needs or their skills changed, health and safety checks were carried out, infection control tasks were completed or when recruitment was carried out. The registered manager did not always ensure people and staff were protected against the risks of unsafe or inappropriate support and practice because accurate records were not maintained.

The registered manager kept current people's and home management records securely in a locked office. However, we found an unlocked storage room upstairs that had various items stored including old confidential records of medicine sheets and care notes. The records were not archived appropriately and safely to maintain confidentiality.

This was a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had defined roles but did not always understand their responsibilities in ensuring the home met the desired outcomes for people. We saw people and staff had good and kind relationships and there was good communication. We observed friendly interactions and respectful support provided to people. However, not all staff understood the importance of respect and dignity. From speaking with staff we could see they were interested and motivated to make sure people were looked after well and able to live their lives the way they chose to. We observed some good practice. However, during the inspection we also observed some practice that was poorly managed. We observed the organisation of staff and their work did not always have a positive effect on people's support and care.

Staff had meetings and discussed different topics including practice at the home, care and support of people, care planning, safeguarding, medicines and training. Annual questionnaires were used to seek the views of people, relatives and other stakeholders. We reviewed the last survey when we inspected in May 2014. The next survey was due to take place in January or February 2015.

People, relatives and staff said they could raise any issues with the management. All relatives said the team and the registered manager were very friendly and approachable. They had built good relationships and communication between each other.

Accidents were recorded and monitored and actions were taken to address them. On the day of our inspection, one person was involved in three incidents during the day related to them being distressed. The incidents were not recorded separately on incidents forms. Only one entry was made in the person's daily notes. There was no entry of

Inadequate

Is the service well-led?

these three incidents in the handover book to make sure all the staff were aware of what had happened. The registered manager did not audit incidents to identify trends so actions could be taken to reduce the risk of recurrence.

We spoke with the registered manager about the current challenges and concerns with the service. They were addressing the recent issues raised, and working with the local authority to complete an action plan for improvement. The plan would be addressed with staff so that lessons could be learned and prevent recurrence in the future. The registered manager said they would ensure everyone could come to them to bring up any issues so they could resolve them as soon as possible. Openness and transparency were things the registered manager wanted to work on and improve.

We spoke with staff and overall the feedback was positive in many areas. For example, being happy and content in their roles, being able to gain further professional development and enjoying the support and care they gave to people. Staff said: “We are happy and content in our roles” and “I enjoy this job”. Staff said the communication was good to keep up to date with important information. They felt supported by their team and the registered manager.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use service were not protected from unsafe or inappropriate care as the registered person did not operate effective systems to regularly assess and monitor the quality of services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered person did not ensure that people and staff were protected against identifiable risks of acquiring an infection by not maintaining premises fully clean and not using appropriate personal protective equipment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person was not protecting service users against the risks associated with the unsafe use and management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person had not made suitable arrangements to ensure the privacy and dignity of service users.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person had not ensured the records relating to service users and staff were kept securely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person did not operate effective recruitment procedures to ensure people were safe from risks of being cared for by inappropriate and unfit staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure staff that received adequate training to be able to deliver safe care and support people.