Runwood Homes Limited

Mulberry Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

Mulberry Court provides personal care and accommodation for older people. Many people living at the home were living with dementia. Mulberry Court is registered to provide care for up to 84 adults. At the time of this inspection 75 people were living at the home. Mulberry Court comprises of a purpose built building offering accommodation over three floors. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The local Clinical Commissioning Group (CCG), which is a group of health professionals who work for the NHS, recently shared their concerns they had about the home with us. At this time some people's relatives

had also contacted us and told us about the concerns which they had about the home. We looked into those issues during the inspection.

People did not have detailed and full risk assessments. With accompanying plans for staff to follow to ensure their needs were met in a safe way.

We observed staff supporting people to move in unsafe ways. Other health professionals told us that they had also seen this happen before. The leadership of the home were not fully responding to these concerns and looking at ways to prevent this from happening again.

Following a serious safeguarding incident and there was not a full investigation into what had happened to try and prevent it from happening again. We found that staff knowledge of how to protect people from harm was not complete.

There had not been an evacuation drill. Other systems were not in place to maximise people's safety, if there was a need to evacuate the building in the future. Recently a person had gone missing when the alarms were activated.

We saw that staff were not always adhering to good infection prevention and control practices.

The management of the home were not checking that staff always had the skills and knowledge to do their job well. We saw examples of poor staff practice which the leadership of the home had not identified. Staff did not receive training in areas relevant to all the people they were supporting. Some people had particular cultural needs, but staff did not receive training on this.

People were not always treated with dignity and respect. We observed that some staff treated people in a disrespectful way. Staff were not always caring towards the people they supported.

We found that people did not have personal assessments which explored their needs as an individual, their interests and backgrounds. Reviews of the care which people received were not holistic. These reviews were not used as an opportunity to capture their views about the care they received at the home. When the service had captured some of this information, they were not using it when they designed and planned activities at the home.

The service was not considering people's personal spaces, their bedrooms. The service was not checking if people liked them and needed support to make them personal and relevant to them as individuals.

The management of the home and the provider were not completing quality and robust audits to test the quality of the service. Robust investigations were not being completed to learn from incidents, with strong measures being put in place to prevent these from happening again.

These issues constituted breaches in the legal requirements. There were breaches of seven regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Relatives told us there was not always enough staff to meet people's needs. We found that people were not being supported to walk and move about the home by staff as a way to promote their ability to mobilise independently. Staff also did not spend time chatting and talking with people.

People were receiving their medicines appropriately by staff. The management of the home had worked with the CCG recently to improve how they did this. Although some people's prescribed creams were not being stored in the correct way.

Some staff were not supporting people in an inappropriate way to eat their food. People were being rushed into the dining rooms and some people were being encouraged to eat at a quick pace. People's dining experiences were not considered. We found that lunch time was chaotic. People's food and drinks likes and dislikes were not being fully identified. People were not being asked about their views of the food and drinks they had in a meaningful way. We were not confident that some people's cultural dietary needs were always being met.

People were not always being asked if they consented to the support and assistance from staff. Staff lacked knowledge of how they ought to be promoting people's freedoms.

The leadership of the home was developing links with the local community. They were trialling out a regular holiday experience for some people at the home.

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 safe.

People did not have detailed and full risk assessments with accompanying plans.

People were not always supported to move in a safe way.

Staff knowledge of how to protect people from harm was poor.

Infection control practices were not always being followed by staff.

Fire safety checks were not complete.

We could not be confident there was enough staff to meet people's needs.

Medicines were administered to people appropriately. Not all medicines were stored correctly.

Is the service effective?

Inadequate

The service was not effective.

We found shortfalls in staff competency and the training provided.

People were not consistently supported to eat their food in an appropriate way. People's dining experiences were not considered.

The service was not effectively monitoring some people's food intake.

People were not always consenting to the support they received.

People had access to support from health professionals when required.

Is the service caring?

Inadequate

The service was not caring.

People were not treated with dignity and respect.

Staff were not always kind to people.

People's personal information was not always secured.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

People did not have detailed and personal care assessments and reviews of their care.

There were limited activities taking place. The service was not linking people's interests and experiences with the activities on offer.

People's cultural and spiritual needs were not being monitored effectively.

People's needs were not always met in a personal way which put them first.

Is the service well-led?

Inadequate

The service was not well led.

The leadership of the home was not monitoring the culture of the home.

Quality monitoring systems were either not in place or were not effective.

The provider was not robustly checking the quality of the service.

The leadership of the home was considering ways to involve people with their communities, but more work was required.

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 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 undertook an unannounced inspection of Mulberry Court on 8 and 10 May 2018. The inspection team consisted of two inspectors, a pharmacy inspector, and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

Before the inspection we had been in contact with a representative from the local authority contracts team. They told us about concerns raised by the Clinical Commissioning Group (CCG) which is a team of health professionals. We looked at the notifications that the manager had sent us in the last year. Notifications are about important events that the provider must send us by law.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 16 people who lived at the home, 10 people's relatives, four members of staff, the chef, the deputy manager and the manager of the home. We also spoke with two visiting health and social care professionals. A District Nurse and a Social Worker. We looked at the care records of seven people, and medicines records of people at the home. We also looked at the recruitment records for three members of staff. During our visit we completed observations of staff practice and interactions between people at the home and the staff. We also reviewed the audits and safety records completed at the home.

Inadequate

Is the service safe?

Our findings

We inspected Mulberry Court in March 2016 and found the service was safe. When we visited in May 2018 we found areas which required improvements to be made.

Concerns had been recently reported by the local Clinical Commissioning Group (CCG). This is a team of professionals within the NHS. Some of these concerns related to unsafe moving and handling techniques used by staff at the home. When we inspected the home we observed four separate occasions when staff did not support people to move in a safe way. In two examples staff did not prepare the area so there was sufficient space to support these people to transfer from a seated position into their wheelchairs. In three examples of staff supporting people to move, we saw staff manually helping people to change positions. This is not safe practice for both staff and for the people involved. We told the registered manager about these observations.

On one occasion two members of staff supported one person to transfer while the person was coughing. The two members of staff did not stop and offer this person assistance and ensure it was safe to transfer them into a wheelchair. During this transfer the person knocked their leg against their wheelchair. They were seen rubbing their right lower leg. Staff did not respond to this. They had not considered how close the wheelchair was to the chair. On another occasion during a transfer a person fell backwards in between their chair and their wheelchair. A further occasion was when a relative was supporting their relative to move from their wheelchair. This person also fell between their chair and their wheelchair. Staff who were in the same room did not intervene. The actions of staff put these individuals at risk of falling and sustaining an injury. We also spoke with the registered manager about these observations.

We spoke with a visiting health professional who said when they observed poor moving and handling events they alerted the registered manager. However, they found that no real action was taken to address this issue. Meaningful action was not taken to try and address this overall concern for example staff were not retrained or monitored. Also no overall investigation was launched to find out what was going wrong in relation to staff supporting people to move and transfer from one position to another. Therefore, no measures were put in place to correct these issues to ensure people were safe when they were being supported to move. We advised the registered manager and the regional manager that work was required in this area, to ensure people are always safe when being supported to move.

In 2017 an incident in the home occurred but staff did not report it to the manager for two days. Whilst appropriate action was then taken, the manager had not fully explored the reasons for the delay in reporting. Without understanding this they were unable to demonstrate what needed to be done to reduce the risk of incidents not being reported promptly again. Delays in reporting could lead to people not being protected from unsafe or unsuitable care.

The registered manager told us about some of the action they took to respond to this safeguarding event. However, other steps had not been taken such as revised training for all staff. The management of the home

was not checking staff knew what constituted abuse and what they must do if they see abuse occurring. No thorough investigation was launched and robust systems were not put in place to try and ensure this did not happen again.

We spoke with four members of staff to check their understanding of abuse and what they must do if they witness abuse taking place. Two of these members of staff could tell us the different types of potential abuse which could occur. However one senior member of staff and another needed support to answer this question. All the staff we spoke with said they knew there were other agencies outside of the provider and away from the home, which they could report their concerns to. However, no one could tell us who these agencies were. Staff told us that they would research this if they needed to. We raised our concerns about poor staff knowledge with the registered manager. They agreed that it ought to have been better, given recent incidents.

We also spoke with the four members of staff about their understanding of how to protect people from experiencing discrimination. Staff also did not have a clear understanding of this. All the staff we spoke with were not aware whether certain people living at the home were more vulnerable to experiencing discrimination in some way. There was a range of people from different ethnic backgrounds living at the home. Staff had not considered this. We did not see any examples of discrimination but this lack of awareness put some people at the potential risk of experiencing discrimination.

We looked at a sample of seven people's risk assessments. These did not explore the risks which people faced in any real detail. They did not give step by step guidance for staff about how to manage these risks. For example, one person was living with a mental health condition. This was not explored with any detail in their risk assessment. The assessor had associated it with dementia and had not considered how this risk needed to be managed. We showed this person's risk assessment to the registered manager; they agreed with us, that this risk had not been suitably explored. This meant that there was a risk that staff would not respond to this person's mental health needs appropriately.

In some cases the risk was identified but it had not been meaningfully assessed. Statements in the risk assessment did not give us confidence that staff knew what to do to ensure people were safe. For example, one person was living with epilepsy. In their risk assessment and the plan talked about what to do if this person had a seizure it said, "Staff are not to panic." It went onto say that staff are not to put anything in this person's mouth when they are having a seizure. We showed this assessment to the registered manager. They could not explain to us why this information is in the assessment. This should be standard practice from staff when a person is having a seizure. This person's risk assessment did not go on further to explore this risk. It did not explain how this person can present before a seizure, how staff should monitor this risk and what type of epileptic seizure(s) this person has.

One person was at risk of experiencing a breakdown to their skin. Their risk assessment had identified this. Their care plan stated staff were to support this person to move at certain times. However, we spoke with two senior members of staff who gave us conflicting information about this person's care. Therefore, there was a potential risk that this person's skin care needs would not be met by staff, and they could experience a break down to their skin.

During our visit we were told by a member of staff which was confirmed by the registered manager that a person who was living with dementia had, "Barricaded themselves into their room." Staff could not enter to give this person their medicines or to check they were safe. We looked at this person's risk assessment with the registered manager. We both found that this risk was not identified at all. There was no plan of action for staff to take when this happened. We asked the registered manager if there was a plan in place to ensure

this event was thoroughly investigated after it had occurred and this person supported. There was no such plan.

Fire safety checks were taking place. People had emergency evacuation plans in place; however these plans did not contain people's photos to help staff to easily identify each person. There was poor supervision of people when alarms had been activated as on one occasion, a person left the building and went missing. There had also not been an evacuation drill involving people at the home. Even though the home supported up to 84 people.

During the inspection we considered the hygiene of the home. A person led us to a sink in the kitchenette area of one of the lounges. They told us that there was often an unpleasant smell coming from the sink holes. We noted this was the case in another kitchenette in the home. We entered one person's bedroom who needed to be hoisted to use the toilet. We found faecal staining on this equipment. The member of staff had not cleaned it after the equipment was used.

When we observed lunch one person's relative told us, "Today is the first time we saw carers using aprons and gloves; we've never seen them using these before." We saw staff entering the dining rooms asking where these items were being stored. During lunch we also saw a member of staff serving people their food. They were not wearing gloves. We saw this member of staff holding plates to serve food which involved them putting their thumbs on the plates as they held them. Later we saw them washing their hands, but they did not use hand soap but gently ran their hands under the running tap. One member of staff was wearing a uniform which had old food stains on it. We concluded that staff were not following good infection control practices.

The above issues constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we looked at the checks completed about new members of staff to ensure they were safe to work with people at the home. Staff had completed Disclosure and Barring Service (DBS) checks in place. Staff had proof of their identities and two references. However, out of the three personnel records we looked at, all three did not have full employment histories. This is an important check to ensure they had no unexplained gaps in their employment history.

We considered if there were enough staff to meet people's needs. We noted that a lot of people spent most of the day sitting apart from when they were supported to move to the dining room. A lot of people also spent all their time sitting in their wheelchairs. We also noted that staff did not sit and chat with people. A member of staff had told us that the staff team had been told by a senior member of staff that during our inspection staff were not to complete people's daily records. We asked why and we were told staff were to spend more time with people whilst we were at the home. These factors could be indicators that staffing levels were not sufficient.

At this inspection we spoke with people's relatives about staffing levels. One person's relative said, "There's never enough staff. If [name of relative] needs something, we often can't find anyone to help." Another person's relative told us, "Staff are really hard working here, they (provider) could certainly do with bringing a few more, we found [name of relative] is often soiled." One person's relative told us that they visit as often as they do, because they are not confident that their relative's needs are always met in a timely way.

One member of staff said that there have been times when staffing levels were below the recommended amount, as defined by the registered manager and provider. However, other members of staff said they felt

there was enough staff. We spoke with the registered manager and the regional manager about this. They said that they were using the same quota of staff, as if the home was full, and it was not. We shared our views about staffing levels with them.

We concluded that we could not be confident that there was always enough staff to meet people's needs safely and in a timely way.

During our inspection we looked at whether people's medicines were being administered and stored in a safe way. We concluded that people were receiving their medicines as the prescriber had intended. However, we found that some people's prescribed creams were being kept in their rooms. These products must not be stored above certain temperatures. If they are this could reduce the effectiveness of these products. The service was not monitoring the temperature of people's rooms to check this issue.

People told us that they felt safe. One person said, "I do feel safe around staff." Another person said, "I feel very safe here than at my home." A person's relative said, "I do feel very safe for my [name of relative]." A further person's relative told us, "I know my [relative] is safe here, I can go home and not worry about [relative]."

We saw records showing that the fire service had visited the home in December 2017. Actions had been taken to resolve fire safety issues identified from this visit. We also saw that various equipment was being tested to ensure it was safe to use.

Inadequate

Is the service effective?

Our findings

We inspected Mulberry Court in March 2016 and found that the service was effective. When we inspected the service in May 2018 we found areas where improvements were required.

During the inspection we identified areas of staff practice which showed that staff training was not effective. We observed several incidents of unsafe moving and handling practices. Staff knowledge about safeguarding people from potential harm and abuse was poor. Staff did not have a clear understanding about protecting people from discrimination. When issues with staff practice had been identified there was not a robust response to these.

We were shown a record of a training program. This showed that most staff had up to date training in areas relevant to their work. However, staff did not always receive training in areas relevant to the people they were supporting. For example, no training had been provided to help staff understand the needs of some people who were living with Parkinson's disease, mental health conditions and epilepsy. No training was also given to understand some people's cultural or religious needs. Some training courses were only provided once rather than revisited or refreshed regularly. This included 'dementia care.' There was no ongoing training in this area even though this was relevant to the people the service supported. There was also no meaningful checking or testing to see if the training provided was effective.

We asked staff to tell us about their most recent training. Three out of the four members of staff we spoke with could not remember the last training they had. One member of staff said they found the E-learning training, "Was boring." We asked them about the face to face training they had, they told us that it was better than the E-learning training. The other three members of staff said that the training was generally good but they could not tell us why they believed this to be the case.

After staff had completed their induction to their work we were told that staff competency and knowledge was checked. We looked at these documents. These did not evidence how the assessor was satisfied that a new member of staff was competent in certain areas of their work. Also, new staff were asked questions about certain topics relevant to their daily work. However, they were not being asked about their understanding of all the key areas to their work. This was not an effective competency check. We spoke with the registered manager about this who agreed these competency checks were not sufficient.

The registered manager and provider were not completing routine competency checks on staff to monitor staff practice and test if the training had been effective and was being put into practice. During our visit we identified clear shortfalls with staff knowledge and practice in key areas of their work. We also saw a member of staff wearing a medallion neckless and other jewellery which could harm a person when they were supporting them. A member of staff was seen washing a corridor floor on two occasions as people were going to the dining room for lunch. People were walking on this wet floor to get to the dining room. This was very slippery. We spoke with a visiting dementia lead from the provider about this, because we were concerned someone could fall. We saw that they had to tell this member of staff twice to stop washing

the floor. They had not considered that this action was putting people at potential risk of slips and falls.

We observed two occasions of poor staff practice in how these members of staff were treating some people. We asked the registered manager to speak with these members of staff.

Some members of staff chose to work a long shift. This was 14 hours long with an hour for lunch and short breaks. Staff were allowed to work through this lunch break so they could finish early by an hour. However, if they were needed they could not leave an hour early. We concluded that it would be difficult for staff to be effective in their work by working such long hours.

People's relatives had already told us that they struggled to find members of staff and this was a concern to them. This practice of staff working thorough their break time and leaving early also contributed to the issues about availability of staff. It indicated that the numbers of staff and their deployment was not being kept under review. We spoke with the registered manager about this. They had not considered these points before our visit. Consequently we concluded there were insufficient staff to meet the needs of people receiving care.

The above issues constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we asked staff about how they felt supported by the management of the home to do well in their work. Three members of staff said they did feel supported. However, they could not give us any examples or explain to us why they felt supported by the management of the home.

During the inspection we observed lunch. We identified some poor practice by staff when they were supporting people to eat and drink. One member of staff was seen to be putting food into one person's mouth. On two occasions this person made an abrupt movement with their hands when this happened. This could have been an indicator that this person was distressed. However, this member of staff continued to put food into this person's mouth at a quick pace. This member of staff was also talking to the people they were supporting with their food in an abrupt way. We had to intervene to stop this member of staff. We then spoke straight away with the registered manager about this. They spoke with this member of staff, and they were given a different task to do. However, this member of staff was seen later supporting people with their food in the evening. We were not confident that this practice issue had been resolved in this time frame. The registered manager had no assurances that it had.

The dining experience was chaotic. People were being hurried into the dining room or woken abruptly to go into the dining room. When people were seated in the dining room, they were being offered two meal options. Two meals would be platted up to show to people. This was to help people to make a choice. However, we noted in one dining room the member of staff serving the meals needed to be reminded to serve two plates to show people first. We saw that one person had asked for chilli and rice but they were given chilli and mash potatoes, they did not eat this. In this person's care record, it stated they did not like mash potatoes.

Limited consideration was given to people's dining experience. Music was playing but this was drowned out by the sound of staff telling the member of staff serving the food what people wanted. Staff were seen and heard shouting, "We have two fish over here." "Three fish on this one (table)." Also, there was a lot of banging of metal serving utensils on plates by the member of staff serving the food. In one dining room four people sat near two large white buckets on a trolley. Staff were putting people's left overs from their lunch and their drinks into these buckets. No attempt had been made to conceal the buckets. This could have undermined

some people's dining experience. In one dining room people were not offered a choice of drinks. Only one drink option was offered.

Staff did not check in a meaningful way if people enjoyed their food and drinks. Often this was standing over people and not at their eye level. One member of staff said to one person, "Is it very nice?" This was a concern to us as staff were not asking open questions to give the person an opportunity to say what they thought about the food. Also, the manner in which staff asked this question could appear intimidating.

We saw some people who were living with dementia struggle to eat their food. We saw two people confuse the table cloth which had a pattern on it, with their own food. The menu had small writing on it. Dementia friendly equipment and practices were not being used.

The registered manager and chef said they devised the menu from speaking with people. The chef said that they asked people how they found the food each day. We did see them doing this on both days we inspected the service. However, this involved the chef entering the dining rooms and asked people in a public way if they liked the food. People's opinions of the food and their meal experience was not being sought in other ways. The service was not capturing people's food likes and dislikes in any detail.

Some people had specialist cultural diets such as Halal food. We spoke with the chef about this. We asked them to explain to us what this meant in terms of what people could eat who had requested a Halal diet. They told us that these people cannot eat pork. When we asked them to explain further they were unable to add to this or show us any guidelines that they followed. The rules around Halal food are more detailed than this. We were therefore not confident that the chef was following the correct guidelines for sourcing, preparing and making Halal food. This could put people at risk of eating food which was not reflective of their cultural needs and wishes.

Some people were at risk of being unable to maintain a healthy weight. The chef told us how they followed the guidance of the specialist professionals involved. We looked at one person's care record who had been losing weight. We could see that a referral had been made to a dietitian. However, it was unclear when guidance was stated in this person's care records, who the source of this was.

This person had a food chart in place. It stated that this person needed to eat a certain number of calories. When we asked the hydration and nutrition lead about how they knew this person was actually consuming this amount of calories each day, they did not know. There was no system in place to check this. This person's food chart also recorded how much a person had eaten. Statements were made to say how much this person had eaten. Such as "Full portion" or "Half" but it did not give a measurement of what they were being given to eat. Therefore it was unclear if this person's food intake was being effectively monitored. We looked at another person's food chart and it did not reflect what they had in fact eaten for lunch that day. Also the member of staff completing the chart did not say if this person had eaten their food.

When we also looked at this person's care record it showed that staff were monitoring this person's weight each month. It showed that this person was losing weight from September 2017 to January 2018. It showed that a referral was made to the dietitian in January 2018. This is not timely action. Professional advice should have been sought sooner.

We therefore concluded that further work was required to ensure that people who were at risk of not eating enough were getting the effective support they needed. Staff practice in supporting people to eat was not consistently effective.

The above issues constituted a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we asked people about their views of the food. One person said, "I find the food very tasty and well cooked, but I'm sure it's not for everybody's taste. I like simple food and that is what it is." Another person said, "They [staff] give us proper food most of the time, but I won't eat it if it looks dubious." We heard one person say, "Well I'm hungry so I will have to eat it." We saw one person say they did not like the food; they eventually left the dining room without being offered an alternative.

When we looked at other people's care records we could see that action had been taken when people were not well or if their health needs had changed. We spoke with a visiting health professional and social care professional who were satisfied with how the staff and management team responded to a change in people's health needs. A relative had told us that due to the staff involvement with their relative that their health had improved significantly.

The service was not considering the use of technology as a way of enhancing people's daily care experiences.

The service had not made sufficient attempts to make areas of the home more accessible to people living with dementia. Each floor of the home had a theme and the corridors were decorated. However, it was unclear what the themes were and how these helped to orientate people or interest them. The ground floor had a theme of London buses and tube maps. We asked staff to explain this to us. One member of staff said sometimes people talk about using buses. Throughout our time at the home we did not see any people referring to this decoration. We observed that people were entering other people's rooms. We saw one person sleeping in two different bedrooms during the day. Two relatives we spoke with told us that this often happens. There was no real attempt made to orientate people to their rooms.

There was a café for visitors and their relatives to use. There was no available space apart from people's rooms for people to have more privacy when visitors came. There was a large garden with raised beds. We did see staff encouraging people to go outside during our visit.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We asked staff about their understanding of mental capacity. The staff we spoke with told us how they promoted and encouraged people to make choices about their day to day needs. However, during the inspection we did not consistently see staff promoting choice. One member of staff put a clothes protector on a person without asking their permission first. They said nothing to this person when they did this. Another member of staff moved a person in their wheel chair without asking their permission. As they moved the person they said, "I'm just going to move you over here." The person went "Oh." We saw

occasions when people were not asked if they wanted to go to lunch. One member of staff supported a person to mobilise and transfer from their chair without explaining what they were doing or asking them if they wanted to go to lunch. This told us that people were not being asked and involved in key decisions about their daily lives.

People had assessments in place about their ability to make certain decisions. When some people had a relative in place who had been given certain powers to make decisions on their behalf, this was documented in these people's care records.

We asked staff about their understanding of DoLS. Three members of staff did not have a clear understanding of what this meant in terms of supporting people at the home. We asked a senior member of staff in charge of an area of the home, if they knew who had a DoLS in place and they said they did not know. This meant that people's freedoms were not always being promoted by staff. We noted that DoLS applications had been made when appropriate.

Considering the issues we saw with staff practice in terms of seeking people's permission and their understanding of how to meet people's needs when they had a DoLS in place. We concluded that the service was not compliant with the MCA.

The above issues constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service caring?

Our findings

When we inspected Mulberry Court in March 2016 we found the service was caring. When we visited in May 2018 we found that there were areas which required improvements to be made.

During our visit we observed three members of staff treating people in a way which was not kind, caring, or respectful. We raised these issues with the registered manager.

At lunch time we observed a member of staff go over to a person while they were asleep and say, "Wake up, it's time to eat." This person appeared disorientated and started to talk to the member of staff. This member of staff then ignored what they were saying and started to put spoon fulls of food into their mouth. This member of staff did this in an impatient way with this person. There was no engagement with this person apart from occasionally saying, "Eat it." "Wake up." "Chew your food." "Eat properly, come on." This member of staff spoke with another person and said, "[Name of person] No, or we will have to stop eating." This person could have been reacting to how they were being treated. No other staff intervened or addressed this issue with a member of the management team.

When we were in another dining room we observed a member of staff talking to a person who was declining assistance to eat their food. This member of staff spoke to them in an unkind and disrespectful way. This member of staff said, "Come on you." They were taping this person's plate with the spoon. Then they said, "Come on madam, you do it." Later they said, "Right you little madam." Before this the member of staff mimicked eating the food themselves, in a similar way one might do to a baby. The tone of voice used by this member of staff was forceful and their voice was loud. This person did not react positively to this member of staff attempts to support them to eat their lunch. Other techniques to support this person were also not considered. Again no other member of staff shared what they had seen with the management team. We told the registered manager about this. They spoke with the member of staff who thought this interaction went well. The registered manager could not offer us a plan or a robust response to this situation and our concerns.

We saw a member of staff go up to a person who was sleeping and say, "It's lunch time." This person awoke in a surprised way. This member of staff apologised for startling them. They then said, "Give me a hug." This person looked very sleepy and was saying to the person, "You did startle me." Without this person agreeing to a hug, the member of staff started hugging this person, even though they had just woken up and had been surprised. This member of staff had not considered how this person wanted to be supported at this moment.

During our inspection we heard a member of staff using offensive language, saying in a loud voice, "Oh [expletive] she does, oh yeah [expletive] she does." There was a group of at least four members of staff talking and laughing in a lounge where people were present and watching them. There was no consideration given to these people. There was no thought that this was their home.

At times we heard staff refer to people as she or he. One member of staff said to another member of staff, "I can't get any of it in her." This was said in front of the person. Another member of staff said, "Just leave it for her." A further member of staff said, "Oh she's off." This was about a person who was becoming agitated. This was not respectful.

A member of staff opened the door to the lounge and it swung and knocked the arm of a person's chair, they looked surprised and stiffened their top half of their body. This member of staff did not respond to this and check the person was okay. Another person was holding another member of staff's arm as they spoke with them. The member of staff quickly walked away from this person without explaining what they were doing. As they walked away, this person was still holding their arm. This persons hand and arm was then pushed behind them with this movement. This person looked surprised by this action. This member of staff also did not react to this.

The dementia lead for the home asked a member of staff to identify a particular individual to them. This member of staff pointed to this person whilst standing in the centre of the lounge. The dementia lead reminded this member of staff not to point at people. A member of staff went up to a person who had spilt their drink and said, "Have you been spilling?" Another member of staff said in a loud voice whilst moving a person in their wheelchair, "I'm taking you to the toilet." A member of staff wiped some food from a person's mouth without asking them if they could do this. This was not respectful.

We also observed a person whose first language was not English. Two members of staff stood over them putting their body weight on the arms of their chair to ask if they wanted a cup of tea. This was not thoughtful and could look intimidating.

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

People's sensitive information was stored in a secure way. Although, some information about people's lives was written on a framed piece of paper on the doors to their rooms. Permission to do so had not been obtained.

We saw that people were rushed at times when eating and getting ready to go into the dining room. Staff were not seen spending real time with people. We concluded that the service was not giving staff the training and the time to do this.

Some people's experiences with staff were different to others. Some people spoke positively about the staff who supported them. One person said, "I cannot praise these girls who work with me enough. They work so hard and I love them to bits." Another person said, "Carers I have are really nice people. I really feel they are my friends." A person's relative told us that, "While we don't think there is enough staff, staff are really nice."

We spoke with staff who were able to tell us how they promoted people's dignity when they supported people with their personal care needs. One person's relative told us that, "They (staff) always knock on [relatives] door before they come in even if it is open."

Relatives visited throughout our two day inspection. They told us that they felt welcomed and at ease at the home.

Requires Improvement

Is the service responsive?

Our findings

We inspected Mulberry Court in March 2016 and found that the service was responsive to people's needs. When we visited in May 2018 we found that improvements were required.

When we looked at people's care records people had not had a person centred assessment which explored their needs, backgrounds, preferences and interests. There was limited personal information about people. For example, references were made to people liking music or watching TV. No details were given as to what type of music or particular artists people liked to listen to, or what TV programmes they enjoyed. People did not have a comprehensive list of food which they liked and did not like. Often there was a statement stating, "Likes most foods." In one person's assessment it stated that the person needed assistance with joining in, when activities took place. It did not consider how to help this person engage with activities. What type of activities they liked and how they preferred to take part in these. Another person's care assessment stated that the person did not, "Like the activities at the home." No recorded process had been undertaken to consider what activities the person may like to do. No investigation was completed to see what people's views were of the activities offered to people.

Some people's care assessments had statements which indicated staff did not know the person or they were not treating them in a personal way. One person's assessment stated that they can express challenging behaviour. However, their assessment did not say what this was or how staff should respond to this. In one person's care assessment it stated that the person can be, "Reluctant to go to bed." It did not explore why and if this was an issue. One person had, "Frequent hallucinations." Their assessment did not try and consider if there were patterns to this. There were no identified techniques for staff to help this person manage these moments. In another person's assessment it stated that staff are to speak firmly to [Name of person], like "No, you should not do that".

People's cultural needs were not fully explored and recorded in their assessments. There was lack of information for staff to follow regarding this need. One person followed the muslin faith; no information was recorded about what this meant for this person, and whether staff or the management of the home needed to assist with this. Another person's care assessment stated that they were Christian, but it did not state what denomination they followed. Some people ate Halal food; there was no information to explain to staff what this meant in practice. When we asked the registered manager if there were people who lived at the home with different cultural and language needs to most people, they went through the list of people at the home. They then said, "Oh, we have quite a few people here with diverse needs." We found there was no overall awareness or real consideration of this fact. There were no assurances the service was meeting people's cultural needs. No one was checking or testing this.

We were told that two people did not speak English. One of these people had two staff allocated to assist them with their communication needs. Another person had no such support. The management team had not considered other ways to help with this person's communication needs. We observed staff did not know how to engage with this person and often shouted or pointed at objects. The person appeared withdrawn

and quiet. However when we spoke with them they smiled. During our visit they would smile back at us and wave. This told us that this person was willing to engage with people but was not routinely given this opportunity. They did not react this way with any member of staff during our observations.

Despite these issues we asked staff if they looked at people's care records to get to know people's needs. One member of staff said they did not have time to do this. During our two day inspection we did not see any members of staff looking through people's care records.

We visited people's rooms. Some people had a lot of involvement from their relatives. These rooms were personalised, with personal objects and items such as bedding. Other people's rooms were stark looking. On one person's care assessment it stated they liked wildlife and had fond family memories of a particular family holiday. Their room had no reference to these interests and associated experiences.

Two people's rooms had dents and holes on the walls near their beds. Paint work was scuffed in other people's rooms. We went into one person's ensuite bathroom and their glass bathroom cabinet had two long cracks running down it. No one had identified this issue. We told the registered manager about this issue with the bathroom cabinet. We later checked that the glass had been replaced. One person had their dentures lying in their open bathroom cabinet. On the other side was a container for the dentures, but it had not been used. Continence products and dressings were not stored discreetly in people's rooms. One person had a pair of shoes in a box of surgical dressings.

In people's rooms which had limited or no personal items these people also had very limited toiletries. Often two items. We spoke with the registered manager about this. They said 'key workers' would purchase items from the home's shop when people ran out of toiletries. People's assessments also did not explore if people liked particular brands or products.

There was photographic information about appropriate mattress care attached to the side of some people's wardrobes. This was the side people would see when they laid in bed and woke up and went to bed. It showed a picture of a neglected mattress which had faecal and urine stains on it. These pictures had the caption, "What lies beneath." In one person's bedroom there was a large poster of how to use a sling for a hoist. There had been no attempt to personalise these spaces. Information and materials were present to support staff not the people who lived in these rooms. On people's front doors there was a brief 'snap shot' about people's backgrounds. Again this was not to help people orientate themselves to find their rooms, but benefited staff. Some of this information was personal but it was displayed in a public space.

When we visited there were limited activities taking place. The activities board was small and difficult to follow. It had a busy pattern behind the actual schedule. This would make it difficult for some people to read it. People had items on tables in front of them when they were in the lounges. However, staff were not sitting with people and engaging people with these items. Only the provider's dementia lead did this, but they were only visiting the home that day. During the two days we inspected the home staff would occasionally appear with a large inflatable ball. They would start throwing this at people. Sometimes they did not explain what they were going to do. Some people had been sleeping and were woken up with this suggestion of playing the ball game. Staff did not clear people's tables of drinks when they started to throw these balls at people. One person was later seen asleep with their eyes closed and their head tilted to the side, holding one of these large balls. Staff had not considered to remove the ball while they slept.

On one of the days we inspected the home there was a church service. This started without any introduction or planning. It was being held in the large conservatory which was connected to the lounge on the ground floor. Around this church service other people were talking. We heard a member of staff washing up in the

kitchenette. One person who was not a practicing Christian was left sat in the church service. They had not been asked if they wanted to take part in this service. They were still sitting in the same chair later that afternoon. Full consideration had not been given to this service and event.

When we asked people about their views of the activities in the home we had negative responses. One person said, "I try word puzzles but I'm not very good at them. I would much prefer to do something active." Another person said, "Weekends could be very long and dull, especially if my family can't visit." A person's relative told us that, "Sometimes over the weekends is very quiet, not even music playing, there are no activities, even [name of relative] said that it is so boring."

We saw some people returning from a trip to a local school. We were told that this was a regular event. The deputy manager told us about plans for some people to have a holiday to Great Yarmouth hopefully on a regular basis. There was a poster about this in the home. The deputy manager said they had planned a "Test run." Although this was positive, these trips only involved a small amount of people at the home.

Relatives told us that staff did chat with their relatives when they visited them. However we observed that staff did not chat and spend time with people as part of their working day.

The above issues constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked to see if people had end of life plans in place. Most people did, although one person's file out of the seven we looked at did not. However, these plans were not detailed. They did not fully explore how and where people wanted to be supported at the end part of their lives. These plans were being reviewed by staff; they were not addressing the limited information in these plans with the person or their relatives.

The service had a complaints process in place. However, this information about how to raise a complaint was not routinely shared with people and their relatives. During our visit we observed a 'residents meeting' which was being held in a lounge. How to make a complaint and what this meant was not mentioned. We spoke with relatives who said they have and would talk to the manager if they had a complaint to make.

Before we visited Mulberry Court a person's relative contacted us at the CQC to share their complaint with us. This complaint had not been concluded but we could see from the correspondence from the registered manager that they had at that point responded appropriately. One person's relative felt their complaint and concerns about the care of their relative was dealt with in a "Transparent way." However, we spoke with a relative who was reluctant to complain due to how a previous complaint had been initially handled.

We concluded that there were positive elements to how complaints were managed, but there were still areas where improvements were required.

Inadequate

Is the service well-led?

Our findings

When we visited Mulberry Court in March 2016 we found that the service was well led. However, when we visited in May 2018 we found that there were areas where improvements were required.

During this inspection we identified numerous breaches of the Health and Social Care Act 2008 which reflected on how the service was being led.

The registered manager and provider were not monitoring the culture of the home in a real and evidenced based way. We identified issues with the culture of the home. Poor staff practice was not being identified by staff and shared with the management of the home. There had been a significant safeguarding incident five months ago which questioned the transparency and culture of the home. However, no investigation and action was taken to consider if there was an issue with the culture of the home. We identified issues with how some staff treated people, no robust action was taken or plans made to resolve these issues.

Health professionals had raised concerns about how people were being supported to mobilise. They did not feel confident action had been taken to address these concerns. When we visited we also found issues with how staff supported people to move. This confirmed no effective action had been taken. There had not been an overall assessment of how staff supported people to move. There was no ongoing monitoring of this. The effectiveness of the training had not been reviewed.

We were told about some recent incidents when errors had occurred and people were put at risk. One incident potentially involved a person being supported with incorrect equipment. There was no real investigation into this. A senior member of staff checked with staff how this person's needs were being managed recently to see if their needs had changed. The investigation was not robust. We spoke with the deputy and registered manager who agreed that this particular investigation was not robust. We could not be confident that there was a culture and systems in place to investigate in an open way when something went wrong and prevent it from happening again.

There was lack of checking the quality of care provided. Staff were not routinely being monitored to see if they were fully competent in their roles. There were gaps in staff knowledge and the management of the home had not considered and sought assurances if the training provided was effective and sufficient to meet people's individual needs. There was lack of senior staff presence to oversee the practice of staff. We also found practice and knowledge issues with the senior staff. During our visit we saw that the registered manager was not present around the home. There was no evidence of daily quality monitoring.

We found that there was lack of robust and meaningful audits taking place. People's dining experiences were not being considered. The registered manager was not testing to see if there was enough staff. We found that there were indicators that there was not enough staff. People and their relatives were not being asked if they felt there was enough staff. These potential issues had not been identified until we visited the home.

The management of the home was not considering if people's cultural and spiritual needs were being met. This had not been considered as an area staff needed training in. There was no checking to see if there was enough social opportunities for people, which they found enjoyable. It had not been checked if staff had enough time with people, and had the skills and knowledge to engage with people in a meaningful way. The quality of people's experiences of their rooms had not been considered or identified.

The registered manager was checking that people had regular reviews and had assessments in place. However, they were not checking the quality of these reviews and assessments. The registered manager agreed with us that there were gaps and significant shortfalls to some people's assessments and reviews.

There were insufficient systems in place for people to fully share their views of the support they received. People did not have holistic reviews of the care and support they received, by trained staff who knew what this meant in practice. We observed a 'residents meeting' which was held in a busy and loud lounge. The member of staff leading this meeting asked closed questions and questions which could be confusing for people. For example they asked, "What do you think about the service you get." 'Relatives meeting' were not well attended and there was confusion as to when the next meeting was. One relative told us they attended the last meeting but no other relative or member of staff attended. The registered manager was not reviewing these systems and opportunities to gain feedback. They were not considering how these could be improved.

A complaint was in the process of being addressed. We found similar themes to this complaint in terms of what we saw in relation to staff practice and the quality of care some people received.

The provider was not providing regular and robust audits of the service. There was no real evidence that they were speaking with people, staff, and relatives about their views of the service. The provider had not identified the issues which we had at this inspection. On the second day we visited, a dementia lead for the provider was visiting and was addressing some practice issues. We noted that they had last visited the home in March 2018, but their visit prior to this was February 2017. We concluded that more quality monitoring involvement was required from the provider.

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

We spoke with the registered manager about their understanding of the events they must report to the CQC by law. The registered manager had good knowledge of these, but had not known until the end of last year that they needed to report safeguarding events to us. They had since rectified this issue and we had received safeguarding notifications in relation to concerns about people's safety.

The registered manager had worked closely with the CCG in relation to how people were supported to receive their medicines. Positive initiatives had been explored to involve people who lived at the home to connect with their community. However, further work was needed in this area.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (RA) Regulations 2014: Person centred care. The provider had not ensured that the care and support people received meet their needs and reflect their preferences. Regulation 9 (1) (a) (b) (c) (3) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 HSCA 2008 (RA) Regulations 2014: Dignity and respect The provider had not ensured that care and treatment was always provided in a respectful and dignified way. Regulation 10 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA 2008 (RA) Regulations 2014: Need for consent The provider had not ensured that people always consented to the care and support that they received.

Regulation 11 (1) (2)

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 HSCA 2008 (RA) Regulations 2014: Meeting nutritional and hydration needs The provider had not ensured that people's nutritional needs were always being met and monitored. Regulation 14 (1) (2) (4) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Well Led. There were inadequate systems with ineffective leadership to ensure compliance with the legal requirements. Regulation 17 (1) and (2) (a) (b) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Regulation 18 HSCA 2008 (RA) Regulations 2014: Staffing.

The provider had not ensured staff were competent, suitably qualified and skilled to complete their work.

Regulation 18 (1) (2) (a).