Mulberry Manor Ltd

Mulberry Manor

Inspection report

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Mexborough
South Yorkshire
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Tel: 02084227365

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced, and took place on 23 February 2017. The home was last inspected in August 2016, where concerns were identified in relation to how risk and medicines were managed at the home; safeguarding; people's care and welfare; how the provider ensured consent was legally obtained; how people's dignity and privacy was upheld; and the governance of the service. We took enforcement action against the provider and told them that they had to make improvements to the service. We also placed the service into 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.

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. As we have judged that the service remains inadequate for the key question of "Effective" the home remains in special measures.

Mulberry Manor is a 49 bed nursing home, providing nursing and residential care to older adults with a range of support and care needs. At the time of the inspection there were 34 people living at the home.The home is divided into two discrete units, one being designated for residential care, and one for both nursing care and residential care, however, the provider told us just before the inspection that they intended to cease providing nursing care and was taking steps to assess how the five people who were receiving nursing care could have their needs met in the future.

Mulberry Manor is located in Rotherham, South Yorkshire. It is in its own grounds in a quiet, residential area, but close to public transport links.

At the time of the inspection, the service did not have a registered manager. 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 and associated Regulations about how the service is run. The home's manager had applied to register with the Commission and at the time of the inspection the Commission was assessing this application.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Staff were failing to follow care plans and risk assessments to ensure that people were cared for in a safe manner.

We identified improvements to the way medicines were managed, but further improvements were required.

Is the service effective?

Inadequate

The service was not effective. The provider was failing to act in accordance with the Mental Capacity Act 2005 to ensure that the arrangements for people who lacked mental capacity were appropriate.

People told us they enjoyed the food provided by the home, however, our observations of mealtimes were varied and while some mealtimes were well managed others were not.

Is the service caring?

Requires Improvement

The service was not always caring. People using the service and their relatives gave us positive feedback about the home. Staff were well meaning and spoke with people with warmth and respect, however, people spent prolonged periods of time with little staff interaction.

Is the service responsive?

Requires Improvement

The service was not always responsive. Although the home had an activities coordinator, activities only took place in one unit at a time, meaning that at times people had little meaningful activities.

We identified that there were occasions where the provider was failing to act in accordance with the direction of external healthcare professionals.

Is the service well-led?

Requires Improvement

The service was not always well led. Staff praised the leadership of the home and told us they had experienced improved support and guidance in recent months. However, we found that the

governance systems used by the provider had failed to identify shortfalls and breaches therefore further improvements were required.

Mulberry Manor

Detailed findings

Background to this inspection

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

The inspection was unannounced, which meant that the home's management, staff and people using the service did not know the inspection was going to take place. The inspection visit took place on the 23rd February 2017. The inspection was carried out by two adult social care inspectors and a specialist pharmacy inspector. An inspection manager observed the inspection as part of our routine quality monitoring programme, and we were also accompanied by a contracts compliance officer from the local authority who was undertaking their monitoring of the service.

During the inspection we checked records relating to the management of the home, team meeting minutes, training records, medication records and records of quality and monitoring audits carried out by the home's management team and senior managers. We spoke with people using the service, their relatives, staff and one of the provider's senior managers.

We observed care taking place in the home, and observed staff undertaking various activities, including handling medication, supporting people to make decisions and engage in activities, and using specific pieces of equipment to support people's mobility. We observed a mealtime taking place in the home. In addition to this, we undertook a Short Observation 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 inspection, we reviewed records we hold about the provider and the location, including notifications that the provider had submitted to us, as required by law, to tell us about certain incidents within the home. Prior to the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was returned in a timely manner.

Requires Improvement

Is the service safe?

Our findings

When we inspected the home in August 2016, we identified considerable concerns in relation to safety at the home. We rated the service "Inadequate" for this domain, and told the provider they must take steps to improve this area. During the inspection of February 2017, we identified that improvements had been made, although found that further improvements were required.

We asked people using the service whether they felt safe at Mulberry Manor. Everyone we spoke with said they had no concerns about safety. One person said: "I'm safe and sound in my room, and they [the staff] keep an eye on me." Another person said: "I'm happy and safe."

During the inspection we observed that there were staff on duty in sufficient numbers in order to keep people safe. Although we noted that they were not always sufficiently deployed to meet people's needs. For example, in one of the units we noted that people were left for prolonged periods in a dining room without any staff present. One of the people left alone was trying to get up from their chair and was at risk of falling; a member of the inspection team had to intervene to keep the person from falling. We asked one of the people using the service about staff presence and they said: "You often don't see a carer when they are short staffed." We carried out observations in lounges in both units of the home and found there was a marked contrast. In one lounge there was little staff presence and people could not get assistance when they wanted it, but in the other lounge we observed staff were present for most of the time and responded quickly to people's requests.

We found that staff received training in the safeguarding of vulnerable adults and staff we spoke with understood their responsibilities in this area. There was information available throughout the service to inform staff, people using the service and their relatives about safeguarding procedures and what action to take if they suspected abuse.

We checked seven people's care plans, to look at whether there were assessments in place in relation to any risks they may be vulnerable to, or any that they may present. Each care plan we checked contained up to date risk assessments which were detailed, and set out the steps staff should take to ensure people's safety, however, our observations showed that staff were not always acting in accordance with people's risk assessments. For example, one person's file stated that they needed a chair sensor in order to keep them safe. A chair sensor is a piece of equipment that makes an audible sound if the person tries to get up, alerting staff to the incident. We checked the person and no chair sensor was in place. Another person's file stated that when they were walking they should have palm to palm contact from staff to help them mobilise safely. We watched the person moving from one room to another and observed that staff were not providing this assistance. One person's file stated that a hoist should be used when staff are supporting them to transfer, for example, from one chair to another. However, we observed staff supporting the person to move from a wheelchair to a chair and noted that no equipment was used.

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

We checked the systems the provider had for monitoring and reviewing safeguarding concerns, accidents, incidents and injuries. We saw that a member of the provider's management team carried out a regular quality audit of the home, and part of this audit included checking whether there had been any safeguarding referrals or accidents and incidents.. We cross checked this with information submitted to the Commission by the provider, and saw that all notifiable incidents had been alerted to CQC, as required by law.

Recruitment procedures at the home had been designed to ensure that people were kept safe. Policy records we checked showed that all staff had to undergo a Disclosure and Barring (DBS) check before commencing work. The DBS check helps employers make safer recruitment decisions in preventing unsuitable people from working with children or vulnerable adults. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable adults. In addition to a DBS check, all staff provided a checkable work history and two referees.

We looked at eight Medicines Administration Records (MARs) and spoke with two senior care workers and the nurse responsible for medicines. Medicines were stored securely and access was restricted to authorised staff. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. Staff carried out regular checks to ensure balances of controlled drugs were correct.

Room temperatures where medicines were stored were recorded daily and were within safe limits. We checked medicines which required refrigeration and found they were not always stored safely. Temperatures had been recorded for both fridges on the upstairs and downstairs units which were outside of the recommended range for storing medicines and no action had been taken. This meant we could not be sure the medicines stored in these fridges were safe to use. The minimum temperature of the downstairs fridge had been recorded as minus four degrees Celsius between 15 January 2017 and 21 February 2017. We informed a senior staff member who took immediate action to obtain new supplies of insulin for people to ensure they were not put at risk of harm. In addition, only the current temperature had been recorded for the upstairs medicines fridge, which is not in accordance with national guidance. We also found a sample of urine in the upstairs fridge alongside medicines and food supplements.

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

All of the people using the service had photographs and allergy details completed on their MARs; this helps to prevent medicines being given to the wrong person or to a person with an allergy. All of the MARs we reviewed had been completed accurately to show the medicines people had received. We checked the stock balances of medicines in the trolleys and store cupboards and found they were correct.

Some people were prescribed patches; staff used patch application records to record where these had been applied and to ensure patches were removed and applied at the right time. People who were prescribed 'when required' medicines had basic protocols in place to guide care staff when and how to administer these medicines safely, however these were not person-centred. One person's protocol referred to another person in the body of the text. Another person was prescribed a spray to relieve angina symptoms. While the protocol described what the medicine was for, it did not state when medical attention should be sought if the spray did not work to relieve symptoms. Some people were prescribed medicines to be applied to the skin, for example creams and ointments. Topical MARs and body maps were used to record the application of these topical medicines, and to show staff where they should be applied.

Two people were prescribed inhalers to treat breathing problems. We found staff did not always administer

these as they had been prescribed. The dose counters on three inhalers showed fewer doses had been administered than had been signed for on the MAR. We asked one senior care worker to show us how they would administer one of the inhalers, however they were unable to use it properly to administer the dose. A senior staff member investigated this issue and identified that one of the inhalers may have had a faulty dose counter and therefore ordered a replacement on the day of the inspection.

One person was prescribed a slow release pain killer which should be given 12 hours apart. We found on nine occasions in February 2017 the gap between doses had been up to 15 hours. This meant the medicine may not have worked properly and increased the risk of the person experiencing pain.

We looked at three medicines audits from February 2017 and two from January 2017. Clear action plans had been generated to drive forward improvements where necessary, including the provision of extra staff training.

Some staff had received appropriate training in the safe handling of medicines, however the provider could only provide limited evidence of supervision and competency assessments being carried out to ensure staff were competent to administer medicines.

Inadequate

Is the service effective?

Our findings

We observed breakfast and lunch taking place in both units of the home and found that people's experience was variable. Lunch in one of the units appeared to be a pleasant experience; the room was well laid out, classical music was playing quietly and staff were providing discreet assistance. Lunch in the other unit did not reflect this. Loud pop music was playing and there were insufficient staff to provide people with assistance. There was a choice of food, however one person asked if they could have fish as they didn't like the choices, a staff member said: "That's not on the menu." They did not find out whether there was anything else available that the person might have liked, meaning that the person's needs and preferences were not met. However, people we spoke with praised the food, one describing it as "excellent."

Staff were serving people in the dining room as well as taking meals to people's rooms and trying to give assistance. In one of the units we saw that one member of staff left the dining room for a period of three minutes and had taken a person their main meal. When they returned they told us the person had eaten all the meal and then took a pudding. We went to observe the person being given assistance with their pudding and saw they were eating very slowly. It was therefore difficult to understand how the main meal had been eaten so quickly and it was possible that the person had not eaten their meal, meaning that their needs had not been met. Staff in one of the dining rooms were task orientated and were not providing a person centred, enjoyable experience for people. The mealtime experience was poorly organised, and loud pop music was playing. This was in contrast to the other dining room where staff were focussed on people's needs.

In one unit we found people were still sat in their rooms and had not been told lunch was being served. People were calling for assistance and no staff were available to answer the call. We discussed this with the regional manager. They agreed staff could have been better organised and served the people in the dining room first before people in their rooms. This would mean that staff were able to give appropriate assistance to people who required support with their meals which they had not done on the day of the inspection.

We observed one person's experience of breakfast and found that it was disjointed and did not meet their needs. We saw that they appeared to be struggling to eat a bacon sandwich, so a staff member cut it into pieces for them. This aided the person, however, a short time later, while the person was still eating, a staff member told them that they should leave the dining room and a fresh sandwich would be brought to them in the lounge. There was no rationale for this and the person's preferences were not checked. The person then went to the lounge, leaving their breakfast. It was a fifteen minute period before a new sandwich was brought to the person, and we noted it wasn't cut up, which staff had done with the previous sandwich to assist the person. While the person was eating this sandwich, two staff attended and assisted the person to stand in order to make an adjustment to their seating. The breakfast experience for this person appeared to have been oriented around staff tasks rather than the person's needs, and the experience of this person was not considered by staff.

We checked care records to look at information about people's dietary needs and food preferences. The files we checked contained up to date details, including screening and monitoring records to prevent or manage

the risk of poor diets or malnutrition. However, we identified that the provider was not always managing people's nutrition effectively. For example, in one person's file we saw that a dietician had instructed the service to fortify the person's food using milky drinks and additional snacks, however, the person's food and fluid charts indicated that this was not happening; their notes stated they were being offered drinks inbetween main meals rather than snacks and there was no information about what was being used to fortify the person's meals. This meant that the person was not receiving care that a healthcare professional had assessed them as requiring. Another person's records showed that they had lost five percent of their body weight in the preceding four months, but the screening tool used to assess the person's risk of malnutrition did not reflect this, meaning that the risk of malnutrition had not been accurately assessed.

This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at the arrangements in place for complying with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS)

Some of the care plans we looked at showed that the person concerned lacked the mental capacity to consent to their care and support. Where people lack capacity, decisions that are made on their behalf should be made in the person's best interests, and people who know the person well should be consulted for their views about the decision. We found that the provider could not evidence that they had consistently done this. In some of the files we looked at, people's relatives had given "consent" on their behalf for things like having their photograph used by the provider or having staff open their mail. In these circumstances another adult cannot give consent on an adult's behalf and therefore this practice is unlawful.

Where people had the capacity to consent to their care, there was some evidence that the provider had sought their informed consent but this was not consistent. For example, one person's file contained a mental capacity assessment which concluded that they had mental capacity to consent to their care, but there was documentation showing that decisions had been made about them by other people in their best interests rather than their consent being sought. This meant that the provider was failing to comply with the requirements of the MCA

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires Improvement

Is the service caring?

Our findings

We carried out observations of staff interactions with people using the service over the course of the inspection. We found that on the whole staff were reassuring and showed kindness towards people both when they were providing support, and in day to day conversations and activities. We asked people about their experience of receiving care at Mulberry Manor. People we spoke with were very happy with the care they received. One person said: "It is fantastic, I have lived in five care homes and this is by far the best." They added: "They treat you like human beings here and respect your choices." Another person said: "It is absolutely marvellous."

We observed care in both units of the home, one being designated as providing care for people who require personal care only and one being designated as providing care for people who require both nursing or personal care, but saw that staff interaction varied from one unit to the other. In one unit there were lengthy periods of time when there was very little staff presence when people were in the lounge. We asked one person about this and they said: "It gets tedious, there's not really anything to do so I prefer staying in my room." They told us that at times of short staffing they didn't see a staff member. By contrast, in the other unit staff were mostly present in the lounge when people were using it and were available whenever people needed assistance.

We spoke with visiting relatives and asked them about the quality of care their relatives received. Everyone we spoke with were extremely positive about the care and support their relatives received. One said: "I can't praise the place enough." Relatives told us they were kept informed of any changes or incidents and were always made welcome when they visited. They all commented that if they had any issues they would raise them with staff or the manager and they knew they would be dealt with immediately.

Another visitor we spoke with was very happy how staff managed their relative, they told us that at times they could present with behaviour that could challenge and staff were very good at managing this. They told us, "My [relative] can be very difficult to manage at times they are not easy to cope with, yet the staff are very good at diverting and distracting [my relative]. They know them very well to be able to manage this."

We also looked at the written compliments the provider had received from people's relatives. One person had written that their relative's wellbeing was "paramount to the staff." One person who had used the service on a short term basis had written to the provider to say: "A big thank you for everything that has been done for me."

We observed how care was delivered to people who were nursed in bed, but found that they were at risk of isolation. We found at 11:20am one person was still in bed unwashed, their face and mouth were encrusted with food and had not been cleaned. Staff told us they had not yet completed personal care. We went to check on this person after lunch and found they were up and dressed but were not well presented. Their nails were very dirty, their hair was not brushed and they had many facial hairs and still had some food around their mouth. This did not promote the person's dignity, although a senior staff member told us the person did not like having personal care tasks carried out and this may be the reason for their unkempt

appearance. This person had also not been out of their room, yet when someone went into their room they responded positively to the presence and engaged with conversation with body language. We asked staff if this person came out into the lounge or dining area to engage in activities, but staff said they could be very disruptive so this didn't always happen. This meant the person could be isolated and not have their social needs met.

Requires Improvement

Is the service responsive?

Our findings

The home had a dedicated activities coordinator who devised a programme of activities both within the home and in the wider community. During the inspection we saw that people were having manicures and listening to music. The activities coordinator told us that a singer visited every month, and that people using the service attended meetings to decide what trips and outings they wished to go on. The home also held regular events attended by the local community. In our observations, however, we noted that when the activities coordinator was undertaking activities within one unit, there were no activities taking place in the other unit, meaning that people were sitting watching TV for long periods of time with no other interaction or stimulation.

We checked care records belonging to seven people who were using the service at the time of the inspection. We found that care plans were detailed, setting out exactly how to support each person so that their individual needs were met. They told staff how to support and care for people to ensure that they received care in the way they had been assessed. Care plans were regularly assessed to ensure that they continued to describe the way people should be supported, and reflect their changing needs.

We looked at evidence within some of the care records we checked which showed that people had required the input of external healthcare professionals. Where this was needed the provider made prompt referrals, however, their guidance wasn't always adhered to. We noted in two people's files external healthcare professionals had set out directions about how to care for people to improve their health or reduce the risk of harm, but the provider was not following this guidance.

Each person's care records included a range of screening tools, such as charts where staff were required to monitor the person's risk of poor skin integrity or malnutrition. We noted that these had not always been completed accurately, meaning that there was a risk the provider may not recognise and respond to changes in people's health or wellbeing.

There was information about how to make complaints available in the guide provided to people using the service, and in the provider's Statement of Purpose. Relatives we spoke with told us that they would be confident to complain if they needed to. All four relatives we met with commented that if they had any issues they would raise them with staff or the manager and they knew they would be dealt with immediately. We checked records of complaints and found that they had all being dealt with in a timely manner and investigated thoroughly. One internal investigation had been delayed due to an investigation also being carried out by the local authority's safeguarding team, but the provider updated the complainant about this to ensure they understood the delay.

Requires Improvement

Is the service well-led?

Our findings

When we inspected the home in August 2016, we identified considerable concerns in relation to safety at the home. We rated the service "Inadequate" for this domain, and took enforcement action against the provider. During the inspection of February 2017, we identified that improvements had been made, although found that further improvements were required.

The service did not have a registered manager. The home's manager had applied to CQC to register and at the time of the inspection CQC was assessing this application. The manager was supported by a senior manager who was at the home on a regular basis and was involved in the improvement programme which had been implemented since the last inspection. In addition to the home's manager there was a deputy manager and unit managers.

We asked staff about the management of the home. They were all very positive and told us training had greatly improved and they felt supported. One said: "We work well as a team and are supported. I am very happy, really very happy working here." Staff told us they had team meeting every four to six weeks and said the home's manager listened to them and responded to any suggestions for improvement. One staff member said, "We are getting there, things are improving." Another staff member said, I received a good induction including training and feel very supported."

We asked a visiting healthcare professional about their experience of the leadership and management of the home. They told us that there had been considerable improvement in recent months, although said that communication between the two units was variable.

We looked at records of meetings and saw team meetings took place regularly, and were used by members of the management team to inform staff about developments and changes in the home, as well as to discuss standards and targets for improvement. There had been a staff workshop to introduce staff to the new format of care plans, and further workshops were planned to look at dignity.

We looked at the schedule of staff supervisions and saw that all staff had received a supervision in the previous six months, however, there were some gaps in the schedule and it was not clear whether a set frequency was being followed.

There was a system in place to audit the quality of the service. This was carried out by a senior manager within the company. We looked at this and found it was a detailed and thorough audit, which checked all aspects of the service being provided. The audit document included an action plan where issues were identified, and we saw evidence that actions had been undertaken. However, during the inspection we identified areas of concern that the audit system had failed to identify. For example, poor adherence with the Mental Capacity Act; incorrect completion of screening tools; and staff not following the guidance of external healthcare professionals. This indicated that the audit was not always effective.

Further audits took place, looking at areas such as infection control, catering and maintenance. These were

all regularly completed and action plans were devised where actions were required.

It is a requirement that providers display their CQC ratings prominently both within the service and, if relevant, on their websites. We noted that the home's CQC rating was not on display either in the home or on the provider's website. The senior manager told us they believed the ratings poster had fallen down within the home, and addressed this during the inspection. Shortly after the inspection the provider took action to ensure that ratings were also displayed on their website.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have appropriate arrangements in place for obtaining and acting in accordance with people's consent. Where people did not have the mental capacity to consent to their care, the provider did not act in accordance with the law. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not take appropriate steps to mitigate the risks to people using the service, and medicines were not managed in a consistently safe way. Regulation 12(1)(2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not consistently ensure people's nutrition and hydration needs were met. Regulation 14(1)(4)(a)(d)