Minster Care Management Limited

Mulberry Manor Care Home

Inspection report

Wortley Avenue
Swinton
Mexborough
South Yorkshire
S64 8PT

Tel: 01709261000

Date of inspection visit:
28 January 2016

Date of publication:
01 March 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced, and was carried out on 28 January 2016. The provider registered this location earlier in the year and therefore this was the location's first inspection. The location was previously operated by another provider within the same corporate structure, and at its last inspection in January 2015 was rated as "Good."

Mulberry Manor is a 49 bed nursing home, providing care to older adults with a range of support and care needs. At the time of the inspection there were 24 people using the service.

Mulberry Manor is in the suburb of Swinton in Rotherham, South Yorkshire. It is in its own grounds in a quiet, residential area, but close to public transport links and the town centre. The home is a purpose –built building operating over two floors, although when the home was inspected the top floor was not in use.

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

Staff were extremely caring and undertook their duties in a person-centred and patient manner. However, there were not enough staff to meet people's needs, and this meant that at times people had to wait for support when they needed it.

Staff had a good knowledge of people and their needs. Staff could describe people's preferences, their backgrounds and life histories, as well as how to support people to keep them safe and provide the care they required.

We found that although there was a comprehensive training programme, it had not yet been embedded into practice and therefore staff had not received adequate training to undertake their roles. Many staff had not received training in relation to recognising and acting on abuse, or in the Mental Capacity Act and ensuring appropriate arrangements in relation to consent are followed.

The provider had failed to make several, legally required, notifications to CQC. These related to safeguarding incidents and the absence of the registered manager. The registered manager was unfamiliar with some of these requirements.

The provider's system for auditing the service was not fit for purpose, as it had failed to identify or address shortfalls in the service, such as errors and omissions in care plans and legal requirements not being adhered to.

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. Risk assessments were not always accurate or fit for purpose. Staffing levels were not sufficient to meet people's needs, and staff were unable to take breaks due to high workloads.

The provider's systems had failed to identify when the legally required procedures in relation to suspected abuse had not been followed, and not all staff had received training in this area.

Staff had a good understanding of how to keep people safe, and recruitment procedures were sufficiently robust to ensure that only the right staff were recruited to the home.

Is the service effective?

Requires Improvement

The service was not always effective. The majority of staff within the home had not received training in the Mental Capacity Act, and the arrangements for obtaining and acting in accordance with people's consent did not meet legal requirements.

Staff communication was effective, and there was a detailed staff training programme, although it had not been fully embedded.

Mealtimes were an enjoyable experience for people, and everyone we spoke with told us the food was good. Catering staff and care staff knew people's dietary needs and preferences.

Is the service caring?

Good

The service was caring. Staff were kind and patient in their interactions with people, and had a good knowledge of people's preferences and needs.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care was not always reviewed to ensure it met people's needs, and care plans lacked personalisation.

There was a good plan of activities at the home, for people to participate in as a group and individually.

Is the service well-led?

Requires Improvement

The service was not always well led. The arrangements in place for monitoring the quality of the service were not robust enough to identify or address shortfalls in service quality.

The registered manager and the provider had failed to make legally required notifications to CQC

Staff and people using the service gave us positive feedback about the registered manager.

Mulberry Manor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 was carried out on 28 January 2016, and was undertaken by an adult social care inspector.

During the inspection we spoke with staff, the home's manager, and a senior manager. We also spoke with five people who were using the service at the time of the inspection. We checked people's personal records and records relating to the management of the home. We looked at team meeting minutes, training records, medication records and records of quality and monitoring audits.

We observed care taking place in the home, and observed staff undertaking various activities, including handling medication, supporting people to eat and using specific pieces of equipment to support people's mobility. 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.

Prior to 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.

Requires Improvement

Is the service safe?

Our findings

We spoke with three people using the service about whether they felt the home was safe. They all said that they felt it was. One person said to us: "I've not been here very long, I came from [another registered home] and I love this place. They keep you safe and look after you." Another person told us that staff kept them safe by "always looking out for us."

During the inspection we carried out observations of people receiving care to assess whether there were staff in sufficient numbers to meet people's needs. We observed that at times people had to wait for assistance from staff, and there were episodes where people did not receive support when they required it. For example, we observed one person ask staff if they could go to the toilet, but the staff member told them that there weren't enough staff available and they would have to wait. We observed that the person had to wait 10 minutes before being helped to use the toilet. Another person, in the dining area, was not attempting to eat their meal. Staff told us that the person needed help from staff, but that there weren't enough staff to provide them with support as all the staff were already supporting people. After a period of 10 minutes, another service user began to help the person to eat. This put the person at risk of choking as they were being fed by someone who did not know their needs or how to safely feed them. After 20 minutes a staff member was available to support the person to eat, but it is likely that their meal was cold by then.

We asked the registered manager how staffing numbers had been assessed and whether any ongoing analysis took place to ensure that staff were deployed in suitable numbers. They told us that a dependency tool was used, which looked at each person's needs, and the number of staffing hours available. This had concluded that staff were available in sufficient numbers, but this wasn't reflected in our observations. We asked staff about staffing numbers and they all told us that there was a lack of staffing. One staff member appeared to be extremely distressed as they couldn't provide support to people when they needed it, and another was unable to take a break until eight hours after their shift had commenced.

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

We checked whether staff had received training in moving and handling, to ensure whether they knew how to support people to mobilise safely. The provider's training matrix showed that two nursing staff and eight care staff had not yet received this training. Staff we spoke with told us that this contributed to a shortfall in staffing as untrained staff could not undertake moving and handling tasks. We carried out observations of care, and saw that staff used moving and handling equipment safely, and spoke with knowledge about its use.

We found that a large number of staff had not received annual training in the safeguarding of vulnerable adults, including the management team and qualified nursing staff. We looked at records of incidents of suspected abuse, and found that the provider had failed to follow the legally required procedures when addressing such incidents. We identified two incidents in the preceding year where suspected abuse of

people using the service had occurred, however, these incidents had not been notified by the provider to CQC, and one had only been notified to the local authority's safeguarding team when it was identified by an external professional.. We checked the provider's policy in relation to safeguarding and found that the policy did direct staff to notify CQC of any such incidents, but this had not been followed. Systems in place to monitor the effectiveness of safeguarding procedures had not identified these shortfalls.

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

We checked six 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. The majority of care plans we checked contained risk assessments relevant to the person. However, they were not always fit for purpose, and some were absent. For example, one person had a care plan which described them as being at high risk of malnutrition, but there was no information or risk assessment about how staff should manage the risk of this. Another person had risk assessment relating to their risk of injury from hitting out at other people. This risk assessment stated that it should be reviewed every month, but it had not been reviewed for four months. One person had a risk assessment in their file which recorded that they were at risk of harm due to taking reduced fluids. This risk assessment had not been completed so it was not clear what steps staff should take to reduce or manage this risk. We asked staff about how they managed risks in relation to two people using the service. Staff spoke with knowledge about keeping people safe, and could describe how risks were managed.

We checked the arrangements in place for safely managing, handling, storing and administering medicines. Medicines were only handled by qualified nursing staff, although the majority of relevant staff had not received training in this area within the last year. We asked one staff member to talk us through the procedure for ordering, recording, administering and returning medicines, and they were able to describe the process clearly. We checked medication administration records. Staff had signed in the majority of cases when they had administered medication to people, although there were a small number of omissions. Where people required medication on an "as required" basis, often referred to as PRN medication, the reason for administering this, and the outcome, was not always recorded.

There was secure and appropriate storage for all medicines. We checked the records of temperature checks for the medication storage areas. There were records showing checks had been carried out twice daily of the medication room and the storage fridge. These records showed that medicines had recently been stored at a high temperature due to malfunctioning air conditioning. The provider had not sought any advice from the pharmacist about whether these medicines were still safe to use. Medicines which are stored at temperatures outside of the manufacturer's recommended parameters can spoil and become ineffective. A member of the senior staff team told us that this would be looked into to inform future practice.

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 checked a sample of four staff members' personnel files, and found that the provider's policies had been adhered to and all appropriate pre-

employment checks had been undertaken.

Requires Improvement

Is the service effective?

Our findings

We asked two people using the service about the food available in the home. They were very positive about the quality and choice of food available. One said: "We want for nothing when it comes to food, the meals are fantastic." Another said: "The meals are very nice, we've got a good cook." Staff we spoke with knew about people's dietary needs and preferences, and choices were offered at mealtimes which reflected these preferences or requirements. We noted that the home had been awarded five stars from environmental health.

We carried out an observation of a mealtime in the home. The room was well laid out, with well presented tables and condiments available on each table. Most people were given appropriate support to eat if they required it, and staff did this respectfully and patiently, although we noticed one person was struggling to eat their meal but there were no staff available to help. Staff had observed this but were unable to assist due to helping other people.

We checked six people's care records to look at information about their dietary needs and food preferences. Most files contained details of people's nutritional needs and preferences, including screening and monitoring records to prevent or manage the risk of poor diets or malnutrition, although this was not always adequately completed, and we noted some contradictory information about one person's needs and preferences in relation to food, and information in another person's file which did not reflect their current needs.

We checked the provider's training records, and saw that only a small number of staff had received Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training. 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 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)

We found that where appropriate DoLS applications had been made.

We also checked people's files in relation to decision making for people who are unable to give consent. The Mental Capacity Act 2005 sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. People's care plans did not reflect appropriate decision making in accordance with the MCA. For example, one person's file showed that they had bed rails on their bed, but their were no records to show this decision had been reached within the framework of a best interest decision. This person's file also showed that their relative had given consent to their care and treatment, which meant that the MCA had not been adhered to. Another person's file indicated that they

had full mental capacity, but records indicated that staff had sought the consent of the person's relative in relation to their care rather than involve the person themselves.

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

We observed staff providing care, and saw that they communicated effectively as a team to ensure that people's needs were met, but ensured that confidentiality was respected during all communications. Staff understood people's needs, and could describe the assessed way people should be supported. Where people had healthcare needs that could not be met within the home, records showed that referrals were quickly made to external healthcare professionals, and staff we spoke with could describe how they contributed to this.

Staff training records showed that there was a well organised programme of training in the home, which was monitored by managers. Staff were able to undertake training in health and safety, dementia awareness, pressure care and infection control amongst other topics, however, the training register indicated that this programme was not fully embedded as few staff had undertaken all the training required by the provider.

Good

Is the service caring?

Our findings

We asked two people using the service about their experience of the care and support they received. Their responses were consistently positive. One person told us: "It's so much better than the last place [another registered service they had used] the staff are lovely, really kind to me." Another said: "I can't think of a single thing I'd change."

We carried out observations of staff interactions with people using the service during the inspection. Staff were consistently reassuring and showed kindness towards people when they were providing support, and in day to day conversations and activities. Where possible, staff took time to sit and chat with people, although staffing numbers did not allow this to happen often as staff were usually deployed in providing care tasks. The staff we spoke with were passionate about their roles, and about providing good quality care to people.

We spent time in the communal areas during the inspection. From conversations we heard between people using the service and staff it was clear staff understood people's needs; they knew how to approach people and ensured that where possible people made decisions in their own time. Staff we spoke with knew people well, and could easily describe their preferences and how people wished to be addressed or supported. Staff were familiar with people's former jobs and other interests, and had a good knowledge of people's life history, which enabled them to deliver care in a respectful and person-centred manner.

We saw that staff respected people's dignity and privacy. For example, we saw care workers knock on doors before they entered and engaged with people they were supporting before they did anything to assist with care needs. When staff needed to discuss care tasks with each other, this was done with discretion and ensuring that the person's dignity was upheld. When people were being supported to move around the home using specialist equipment, staff routinely talked through the procedure with people first, ensuring that they understood what was going to happen and why. This was done to minimise any anxiety and provide reassurance.

Four staff at the home had been designated as "dignity champions" and there were prompts around the home reminding staff of the underpinning principle of dignity.

We checked six people's care plans, and saw that risk assessments and care plans described how people should be supported so that their privacy and dignity was upheld. However, we noted that care plans did not always contain enough information to ensure that they were truly personalised to each person. The registered manager told us that work was commencing to re-write care plans in a way that would enable them to be more person-centred, but this work was only just beginning.

Requires Improvement

Is the service responsive?

Our findings

There were activities available for people to take part in, both inside and outside the home. There were plans under way for a forthcoming party, and karaoke had recently taken place. People told us they enjoyed the activities available to them, and their care records reflected a wide range of opportunities to participate in activities were offered. A review of people's records showed that in addition to group activities people engaged in one to one activities with staff, including manicures and puzzles. The home employed a dedicated activities co-ordinator, although they were not working during the inspection.

We checked care records belonging to six people who were using the service at the time of the inspection. We found that care plans did not always contain the right information to support people in receiving the care they needed. For example, one person's care plan stated that their records should be reviewed monthly to ensure they still met the person's needs, but this had not been completed for four months. Another person's records showed that they were at risk of harming themselves and others, but the care plan did not set out in sufficient detail how staff should support the person when this risk was present.

One person's file had information about how they should be supported when they were experiencing episodes of anxiety or distress, however, other records showed that this had not always been adhered to, and staff had provided support in a way that had not been assessed as meeting the person's needs. Another person's file contained an assessment stating that they should be "observed continuously throughout the day" in order to keep them safe. We carried out observations of this person and found that they were not always observed by staff, meaning that they were not receiving care in the way that they had been assessed as needing.

Staff told us about one person who needed support with a specific task, and we observed staff providing this support. However, when we checked this person's records we found that the relevant care plan stated that they were independent with this task and therefore did not need assistance. This meant that the person's care plan did not reflect their current needs.

There was information about how to make complaints available in the communal area of the home, and people we spoke with told us they would feel confident in making a complaint should they feel the need to. The provider's complaints policy held information about how complainants could obtain external remedy should they be dissatisfied with the provider's internal complaints mechanism. We checked records of complaints and found that each one was responded to within an appropriate timescale.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager and a clinical lead whose role included deputising for the manager. Additionally, the regional manager visited the home regularly and carried out a documented audit of the service. Staff told us that they found the management team within the home to be approachable. Staff we spoke with were confident in their knowledge about how to raise concerns or give feedback to managers, although they told us they were not always confident they were listened to when they had raised concerns about staffing numbers. There was a whistleblowing policy in place to support staff who had any concerns, and this was available to all staff in the home.

We asked staff about the arrangements for supervision and appraisal. They told us that they had received formal supervision in the past, but weren't sure that it had taken place recently. The registered manager confirmed that supervision frequency had reduced in recent months, but described that they were starting to address this.

The registered manager told us that the regional manager carried out a monthly audit of the home, and this was the mechanism by which quality was audited. They said that in addition to this, care plans, medication and infection control were audited monthly. The kitchen staff carried out all kitchen audits, and the maintenance person undertook a full range of health and safety and fire audits.

We checked the regional manager's two most recent audits, but found that they had failed to identify issues and concerns. For example, in the September 2015 audit paperwork around a specific incident had been checked and recorded as all complete, however, this was not accurate as the provider had failed to notify the Care Quality Commission (CQC) about the incident, which is a legal requirement. The January 2016 audit looked at a recent safeguarding incident but again did not identify that all legally required actions had not been completed.

When we checked information we held about the location prior to the inspection, we identified that the provider had failed to make a number of required notifications to CQC. We discussed this with the registered manager and regional manager. The registered manager was not aware of the requirement to make some of these notifications, and we directed her to appropriate guidance. We asked the regional manager how they monitored this aspect of regulatory compliance. They stated that they had delegated it to a member of administrative staff, but this had not been monitored. This meant that the provider had failed to ensure legally required notifications were made.

We carried out a check of care records, and found that they contained errors and omissions which had not been identified by means of any audit. For example, one person's file contained two contradictory documents about their food preferences. Another person's held two different review records, so it was not clear when reviews had been done, or how to track any progress or deterioration. A third person's file had not been reviewed at the provider's own designated frequency to ensure it remained suitable to their needs.This contradiction and lack of information had not been identified via any form of quality auditing.

We checked the systems in place for monitoring accidents and incidents. The registered manager described that they carried out a monthly audit of all accidents and incidents, to identify any patterns or risk areas. We noted in one person's care plan records which indicated they had been the victim of violence perpetrated by another person using the service. The registered manager was not aware of this, and therefore had not assessed it. The provider had also failed to notify CQC about this incident, which it is legally required to do.

We checked they systems in place for auditing medication. There were records showing that checks were carried out every night by the night staff. However, the audits had failed to identify errors in relation to medicines management. For example, one person's medication records required staff to record when and where they had place analgesic patches on the person's body, but this had not always been recorded. Two of the records we checked showed that people had been prescribed a medicine to take on an "as required" basis, but staff had failed to complete records showing why they had administered this, or the outcome. This showed that the audit was not effective as it did not accurately reflect the standard of medicines management in the home, or identify where improvements or rectifications should be made.

We carried out a check of incidents and accidents at the home. The home's records indicated that two safeguarding incidents had occurred in the preceding 12 months. These incidents of suspected abuse had not been notified to the Commission. As such notifications are a requirement of law, this showed that the systems in place to ensure that the location complies with legal requirements was ineffective.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care 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. 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 17 HSCA RA Regulations 2014 Good governance The provider did not have adequate arrangements in place to ensure compliance with the fundamental standards. Regulation 17(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that sufficient numbers of staff were deployed to meet people's needs. Regulation 18(1)