Galleon Care Homes Limited

Queen Mary's and Mulberry House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Queen Mary's and Mulberry House Nursing Home is divided into two discrete units. Queen Mary's provides nursing care for up to 48 people and Mulberry House provides nursing care and support for up to 24 people with an acquired brain injury. On the days of the inspection, there were 47 people living at Queen Mary's and 12 people living at Mulberry House.

Queen Mary's provides nursing support for people living with varying stages of dementia along with healthcare needs such as Parkinson's, diabetes, strokes and heart disease. Mulberry House cares for people with an acquired brain injury, this included post trauma as well strokes. There was a multi-agency approach to care and support which included physiotherapists and occupational therapists working alongside the care team. The age range of people living at the home varied from 23 –100 years old.

Accommodation was provided over two floors with lifts that proved level access to all parts of the home. Thought and consideration had been given to the environment of the home, making it as comfortable and user friendly as possible. People spoke well of the home and visiting relatives confirmed they felt confident leaving their loved ones in the care of Queen Mary's and Mulberry House Nursing Home.

A manager was in post and was in the process of registering with CQC. 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.

At the last inspection on 28 January and 02 February 2015 we asked the provider to make improvements to the safety and welfare of people, infection control procedures treating people with dignity and respect, ensuring equipment was properly maintained and the monitoring and assessing the quality of the care and support provided. The provider sent us an action plan stating they would be addressed by December 2015. We found our concerns had been addressed and the breaches in regulation met.

People spoke positively of the home and commented they felt safe. Our own observations and the records we looked at reflected the positive comments people made.

Care plans reflected people's assessed level of care needs and care delivery was person specific and in line with the care plans. The delivery of care was based on people's preferences.

The care planning system had been reviewed and records for each person were specific to their needs, with guidance for staff to ensure people received the support and care they needed and wanted. We saw care plans that contained information about people's skin integrity alongside the risk assessment to identify people's individual risk to pressure ulcers. However we did find gaps in documentation that identified that some people's skin had deteriorated to a wound without changes to the risk assessment or care plan. There was no indication of staff awareness of the development of the wound. This was discussed in full and as

requested a full root core analysis was undertaken by the manager with timelines of the pressure wounds following the inspection.

Risk assessments included, falls, skin damage, behaviours that distress, nutritional risks including swallow problems and risk of choking and moving and handling. For example, cushions were in place for those that were susceptible to skin damage and pressure ulcers. The care plans also highlighted health risks such as diabetes and epilepsy.

Nurses were involved in writing the care plans and all staff were expected to record the care and support provided and any changes in people's needs. The manager said care staff were being supported to do this and additional training had been arranged. Food and fluid charts were completed and showed people were supported to have a nutritious diet.

Staff had a good understanding of people's needs and treated them with respect and protected their dignity when supporting them. A range of activities were available for people to participate in if they wished and people enjoyed spending time with staff. People we spoke with were very complimentary about the caring nature of the staff. People told us care staff were kind and compassionate. Staff interactions demonstrated staff had built rapport with people and they responded to staff with smiles. People previously isolated in their room were seen in communal lounges for activities, meetings and meal times and were seen to enjoy the atmosphere and stimulation.

Activity provision was provided throughout the whole day and was in line with people's preferences and interests.

The provider had progressed quality assurance systems to review the support and care provided. A number of audits had been developed including those for care plans, medicines and health and safety. Maintenance records for equipment and the environment were up to date, such as fire safety equipment and hoists. Policies and procedures had been reviewed and updated and were available for staff to refer to as required. Staff said they were encouraged to suggest improvements to the service and relatives told us they could visit at any time and they were always made to feel welcome and involved in the care provided.

Staff and relatives felt there were enough staff working in the home and relatives said staff were available to support people when they needed assistance. The provider was actively seeking new staff, nurses and care staff, to ensure there was a sufficient number with the right skills when people were able to move into the home. The manager told us it had been difficult to recruit nurses with the right knowledge, a deputy registered manager had been appointed and the provider continued to advertise for full time nurses.

Pre-employment checks for staff were completed, which meant only suitable staff were working in the home.

The provider had made training and updates mandatory for all staff, including safeguarding people, moving and handling, management of challenging behaviour, pressure area care, falls prevention and dementia care. Staff said the training was very good and helped them to understand people's needs.

All staff had attended safeguarding training. They demonstrated a clear understanding of abuse and said they would talk to the management or external bodies immediately if they had any concerns, and they had a clear understanding of making referrals to the local authority and CQC. People said they were comfortable and relatives felt people were safe.

Visits from healthcare professionals were recorded in the care plans, with information about any changes and guidance for staff to ensure people's needs were met. There were systems in place for the management of medicines and we observed staff completing records as they administered medicines.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider, registered manager and staff had an understanding of their responsibilities and processes of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff said the management was fair and approachable, care meetings were held every morning to discuss people's changing needs and how staff would meet these. Staff meetings were held monthly and staff were able to contribute to the meetings and make suggestions. Relatives said the management was very good; the registered manager was always available, they would be happy to talk to them if they had any concerns and residents meetings provided an opportunity to discuss issues with other relatives and staff.

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

Queen Mary's and Mulberry House Nursing Home was not consistently safe. Some people's skin had deteriorated to a wound without changes to the risk assessment or care plan. There was no indication of staff awareness of the development of the wound..

Risks to people's safety from health related problems had been identified by the staff and measures had been put in place to reduce these risks as far as possible.

People told us they felt safe at the home and with the staff who supported them. There were systems in place to ensure medicines were handled and stored securely and administered to people safely and appropriately.

Staffing numbers were sufficient to ensure people received a safe level of care. Recruitment records demonstrated there were systems to ensure staff were suitable to work with vulnerable people.

Is the service effective?

Good

Queen Mary's and Mulberry House Nursing Home was effective.

Staff received training which was appropriate to their job role. This was continually updated so staff had the knowledge to effectively meet people's needs. They had regular supervisions with their manager, and formal personal development plans, such as annual appraisals.

Staff had a good understanding of people's care and mental health needs. Staff had received essential training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and demonstrated a sound understanding of the legal requirements.

People were able to make decisions about what they wanted to eat and drink and were supported to stay healthy. They had access to health care professionals for regular check-ups as needed.

Is the service caring?

Good

Queen Mary's and Mulberry House Nursing Home was caring. People felt well cared for and were treated with dignity and respect by kind and friendly staff. They were encouraged to increase their independence and to make decisions about their lifestyle choices. People and their relatives were involved in decisions about their care and treatment.

Staff were highly motivated and passionate about the care they provided. There was a strong ethos of promoting independence and individuality within the home.

Care records were maintained safely and people's information kept confidentially.

Is the service responsive?

Good

Queen Mary's and Mulberry House Nursing Home was responsive. People were supported to take part in a range of recreational activities both in the home and the community. These were organised in line with peoples' preferences and personal goals. Family members and friends continued to play an important role and people spent time with them.

People and their relatives were asked for their views about the service through questionnaires and surveys. Comments and compliments were monitored and complaints acted upon in a timely manner.

Care plans were in place to ensure people received care which was personalised to meet their needs, wishes and aspirations.

Is the service well-led?

Good

Queen Mary's and Mulberry House Nursing Home was well-led. The home's quality assurance framework had improved as mechanisms were now in place to analyse and monitor the effectiveness of their own systems. For example, equipment checks had been undertaken.

People spoke well of the manager and staff. The home had a vision and values statement which governed the running of the home and how care was delivered.

Management was visible within the home and staff felt supported within their roles. Systems were in place to obtain the views of people, visitors and healthcare professionals. The manager was committed to making on-going improvements in

Queen Mary's and Mulberry House Nursing 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 home, and to provide a rating for the home under the Care Act 2014.

We visited the home on the 12, 13 and 14 April 2016. This was an unannounced inspection. The inspection team consisted of an inspector and a specialist advisor with experience of caring for people with an acquired brain injury and people with complex nursing needs.

During the inspection, we spoke with 20 people who lived at the home, six visiting relatives, eight care staff, three registered nurses, one occupational therapist, two cleaners, the area manager, the manager and a physiotherapist.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home.

We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also used communication aids that people themselves used, to communicate with them.

During the inspection we reviewed the records of the home. These included staff training records and

policies and procedures. We looked at five care plans from Mulberry House and six care plans from Queen Mary's and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Queen Marys and Mulberry House Nursing Home. This is when we looked at people's care documentation in depth and obtained their views on how they found living at Queen Marys and Mulberry House Nursing Home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at queen Marys and Mulberry House. One person told us, I feel very secure living here." Another person said, "I have no concerns, I'm happy and safe here." Relatives said, "The staff are very good, they make sure people are safe, even when they want to walk around." Another relative told us their family member was safe and settled and they did not worry about their safety. Staff expressed a strong commitment to providing care in a safe and secure environment.

At the last inspection we could not be assured that people's safety was being promoted and protected or that specialist equipment was serviced. This inspection found that individual risk assessments had been implemented, reviewed and updated to provide sufficient guidance and support for staff to provide safe care. Risk assessments for health related needs were in place, such as skin integrity, nutrition, falls and dependency levels. Care plans demonstrated how people's health and well-being was being protected and promoted. We saw detailed plans that told staff how to meet people's individual needs. For example, continence care was identified and a plan of action for staff to follow such as regular visits to the bathrooms and application of topical creams. Another care plan told staff how to meet their behaviours that challenge in a way that ensured their safety and well-being. We saw care plans that contained information about people's skin integrity alongside the risk assessment to identify people's individual risk to pressure ulcers. However we did find gaps in documentation that identified that some people's skin had deteriorated to a wound without changes to the risk assessment or care plan. There was no indication of staff awareness of the development of the wound. This was discussed in full and as requested a full root core analysis was undertaken by the manager with timelines of the pressure wounds following the inspection. This is an area that requires improvement.

There were people who presented with behaviours that challenged, and staff were seen to manage people in a way that ensured people remained safe. Staff remained observant but respected peoples' personal space and managed to de-escalate situations quietly and professionally. We saw that staff used observation charts that they completed following an incident and these records were used to review triggers and the management of behaviours. It was identified that the terminology used was not always professional and respectful. This was an area that requires improvement.

We observed safe transfers (people being supported to move from a wheelchair to armchair with the support of appropriate equipment). The transfers we observed showed that staff were mindful of the person's safety and well-being whilst being moved. Staff offered support and reassurance to the person being moved. People told us they felt safe whilst being moved by staff. One person said, "I trust them to keep me safe, it's a funny feeling being lifted but they do it well." Peoples care documentation and risk assessments reflected the lifting equipment and size of sling to be used. People had their own personal sling which reduced the risk of cross infection.

Personal risk assessments were in place to enable people to take part in everyday activities with minimum risk to themselves and others. Risk assessments included, managing finances, managing medication, mental health, alcohol and personal care. Each risk assessment looked at the current situation, (identified

need) the expected outcome, or goal to be achieved and actions required to meet this. If possible, staff would write the risk assessment in conjunction with the person and/or family, considering the impact on their well-being of not taking the risk and the benefits for the person of taking the risk. Examples included smoking, relationships or having an alcoholic beverage.

A system was in place to record accidents/incidents with actions taken to prevent them as far as possible. Accidents were recorded with information about what had happened, such as an unwitnessed fall in person's bedroom. The information included action taken to prevent a further accident, such as increased checks and a sensor mat. Audits were carried out for the accident/incident forms to ensure sufficient information was recorded. Accidents were reported to the local authority in line with safeguarding policies.

Medicine records showed that each person had an individualised medicine administration sheet (MAR), which included a photograph of the person with a list of their known allergies. MAR charts indicated that medicines were administered appropriately and on time (MAR charts are a document to record when people received their medicines). Records confirmed medicines were received, disposed of, and administered correctly. People confirmed they received their medicines on time. One person told us, "I get all my medicines when I need them." People's medicines were securely stored in a clinical room and they were administered by registered nurses and senior care staff who had received appropriate training. We observed two separate medicine administration times and saw that medicines were administrated safely and that staff signed the medicine administration records after administration. The clinical room was well organised and all medicines were stored correctly and at the correct temperature. The deputy manager said that she was undertaking medicine audits and had identified areas to improve following a number of medicine errors. There was a clear audit trail that defined what action was taken following errors, such as medicine retraining and competency tests.

People were supported to live an independent life style as far as possible despite living with a wide range of illnesses such as, an acquired brain injury, dementia, Parkinson's and diabetes. The manager and staff understood the importance of risk enablement, this meant measuring and balancing risk. Staff member said, "We want to ensure people live life to the full, taking risks is part of it." The staff team recognised the importance of risk assessment and not taking away people's rights to take day to day risks. With support from staff, people went out shopping and visits to local pubs or restaurants. People were supported to continue smoking under supervision, and to go out with family and friends. Staff recognised the importance of respecting and promoting people's right to take controlled risk and freedom of expression.

Staff had an understanding of abuse and what action they would take if they had any concerns. They identified the correct safeguarding and whistleblowing procedures should they suspect abuse had taken place, in line with the provider's policy. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, anonymously if necessary. One staff member told us, "I would always tell the manager if I thought someone I was looking after was at risk. I'm sure they would do something but if they didn't, I'd let the local authority know." Another staff member said, "I would not hesitate to report anything like that." Staff confirmed the manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence. The registered manager said all concerns were now reported to the local authority, they waited for a response before they took any action and records were in place to support this. This meant people were protected as far as possible from abuse.

Sufficient numbers of skilled and experienced staff contributed to the safety of people who lived at the home. Staff arrangements include separate staffing on a daily basis for each house. This was based on the skills and competency of staff and the individual needs of people. For example, each shift in Mulberry House required a senior carer with competency in medicines. Mulberry House also had people on a one to one

supervision during their waking hours and people with a preference for female staff to provide their personal care and this was reflected within the staffing provided. The ground and first floor at Queen Marys each had a registered nurse to oversee and monitor the clinical care provided. People told us there were enough staff to respond to their needs although they were often 'very busy.' Agency staff were used to cover known vacancies and was well managed with regular agency staff who knew the service being employed. For example the physiotherapist hours were being covered by an agency physiotherapist for a fixed term to provide consistency to people. However there were concerns raised by staff about the deployment of registered nurses (RN). We were told that Mulberry House was now run by an assistant practitioner (senior care staff member) with oversight by the RN based at Queen Marys. We were told by some RN's that they found it potentially unsafe as they could not always respond immediately to issues that arose. An example was that if the senior person on Mulberry was not a medicine giver then one of the RN's from Queen Mary's would have to go to Mulberry House. They felt that this was not safe and placed added stress on to the RN. We discussed this with the management team who told us this was a trial which had started the week before. It was confirmed that a staff meeting would be held to discuss the staff's views. At this time we did not find any worrying trends of medicine incidents or errors that identified that there were unsafe medicine practices since the change in staffing arrangements.

We observed people received care in a timely manner and call bells were answered promptly. The manger undertook random audits on call bell response time. Staff told us that they worked hard to ensure an immediate response and felt the number of staff on duty allowed them to do so. Staffing levels allowed for staff to support people and to take people outside for walks and fresh air. We also saw that staff sat with people chatting and having a cup of tea whilst discussing people's plans for the day.

Recruitment processes were safe. There was a recruitment procedure in place. We found staff records included application forms, confirmation of identity and of the person's right to work. The recruitment process included a thorough interview and the sourcing of references that informed the provider of staff suitability. Each member of staff had a disclosure and barring checks (DBS) completed by the provider. These checks identify if prospective staff had a criminal record or were barred from working with children or adults at risk. There were systems in place to ensure staff working as registered nurses had a current registration with nursing midwifery council (NMC) which confirms their right to practice as a registered nurse. In addition separate files were kept on agency staff employed to ensure DBS checks had been completed along with right to work checks. Those who were employed as registered nurses also had a further check with the NMC to ensure they were registered.

People were cared for in an environment that was safe. There were procedures in place for regular maintenance checks of equipment such as the lift, firefighting equipment, lifting and moving and handling equipment (hoists). Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Health and safety checks had been undertaken to ensure safe management of food hygiene, hazardous substances, staff safety and welfare. People had personal emergency evacuation plans (PEEPs) which detailed their needs should there be a need to evacuate in an emergency. Staff had received regular fire training which included using fire extinguishers and evacuation training.

Good

Is the service effective?

Our findings

People and relatives had confidence in the skills and abilities of the staff employed at Queen Marys and Mulberry House. One person said "The staff are all very good, they all know exactly how to respond to X and get the best results for him." Feedback from visiting health care professionals was positive about the skills and competence of the staff and their willingness to learn. People were complimentary about the food and how they were provided with choice and variety.

People commented they felt able to make their own decisions and those decisions were respected by staff. The staff we spoke with understood the principles of the Mental Capacity Act (MCA) and gave us examples of how they would follow appropriate procedures in practice. There were also procedures in place to access professional assistance, should an assessment of capacity be required. Staff undertook a mental capacity assessment on people admitted to the home and this was then regularly reviewed. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. There was evidence in individual files that best interest meetings had been held and enduring power of attorney consulted. During the inspection we heard staff ask people for their consent and agreement to care. For example we heard the registered nurse say, "Can I get you your tablets now, and have you any discomfort." Care staff were heard asking, "Can I help you to the bathroom before lunch," and "Would you like me to help cut up your food?"

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). During the inspection, we saw that the registered manager had sought appropriate advice in respect of these changes in legislation and how they may affect the service. The manager knew how to make an application for consideration to deprive a person of their liberty and had submitted applications where they were deemed necessary. The manager confirmed that she had attended a training day provided by the local authority and will be cascading training to other staff.

People commented they regularly saw the GP and relatives felt staff were effective in responding to people's changing needs. One relative told us, "The staff are on the ball, they know what they are doing, best care is given because of everybody involved in the care, physio, special nurses and doctors." Staff recognised people's health needs could change rapidly and some people may not be able to communicate if they felt unwell. One staff member told us, "We monitor for signs, changes in behaviour and facial expressions which may indicate something is wrong." People told us they had access to chiropodists, dentists, dieticians, opticians and psychologists. People were also supported with attending appointments.

Records and discussion with staff confirmed that staff liaised effectively with a wide variety of health care professionals who were accessed when required. The staff had developed links to communicate effectively and co-ordinate a multi-disciplinary approach to care. For example, specialist nurses were contacted and involved in planning and reviewing of care for people who had skin damage.

Specialist advice was also sought from mental health care specialists who supported staff in providing tailored support to people who could exhibit behaviour that challenged. One relative told us how specialist advice had been followed and a personalised therapy programme had given some relief for her relative.

Visiting health care professionals told us the working relationship with the staff was constructive and very positive. Staff demonstrated professionalism and a commitment to providing the best care possible working in conjunction with all additional health care professionals available.

The management team organised all staff training and worked with staff regularly to underpin what was needed in the training sessions. These sessions contributed towards staff supervisions by giving staff and the registered manager an opportunity to share and reflect on their practise. Staff received training in safeguarding, food hygiene, fire evacuation, health and safety and infection control. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were competent to work unsupervised. Staff also received additional training specific to peoples' needs, for example care of catheters, dementia care and end of life care provided by the local hospice. Additionally, there were opportunities for staff to complete further accredited training such as the Diploma in Health and Social Care. One member of staff said, "All the staff get training. I have completed a National Vocational Qualification in Care -Level 2 and 3. We all complete mandatory training."

Staff also received training specific to peoples' needs, such as behaviour that challenges, care of people with an acquired brain injury and end of life care provided by a local hospice. Additionally there was specialist training in caring for people living with dementia and epilepsy. Staff also had training in different communication strategies, such as eye blinking and gaze spelling for people who were non-verbal.

We saw staff used their training to assist them in their roles within the home. For example, we observed staff assisting people with their meals in a way that ensured they were maximizing their independence, but assisting discretely. We also observed people moving people safely throughout the inspections in hoists and wheelchairs. We saw staff communicate with people by using special techniques displaying empathy and patience. The therapy team provided skilled expertise in meeting people's care and handling needs. The organisations' psychologists supported the care delivery in identifying and supporting the people's emotional and psychological needs. This was then planned in to their individual plan of care.

Staff received on-going support and professional development to assist them to develop in their roles. Supervision schedules and staff we spoke with confirmed they received supervision and appreciated the opportunity to discuss their role and any concerns. Feedback from staff and the manager confirmed that formal systems of staff development, including an annual appraisal was undertaken. The registered manager told us, "It's important to develop all staff as it keeps them up to date, committed and interested." Staff told us that they felt supported and enjoyed the training they received. Comments included, 'interesting, valuable and the RN (registered nurse) works with us on the floor to make sure we do things correctly.' The therapeutic care team were integrated with care team, which has proved successful and of benefit to the people receiving care.

People told us the food was good and we saw staff asked them what they wanted at mealtimes and with drinks in between. People had an initial nutritional assessment completed on admission. Their dietary needs and preferences were recorded. People told us that their favourite foods were always available, "They know what I like and don't like, always give me my preferred drink, meals are good." A nurse told us, "People have a nutritional assessment when they arrive. We can cater for diabetic, vegan, soft or pureed and any other special diets. We don't have any cultural preferences at the moment but the chef would be able to meet any dietary requirement."

People's weight was regularly monitored and documented in their care plan. Staff said some people didn't wish to be weighed and this was respected, "We notice how their clothes fit, that indicates weight loss or weight gain if they don't want to be weighed." The registered manager said, "The kitchen staff and staff talk

daily about people's requirements, and there is
regular liaison with Speech and Language Therapists (SALT) and GP." The staff we spoke with understood people's dietary requirements and how to support them to stay healthy.

We observed the mid-day meal service on both Queen Marys and Mulberry House. People either ate in their room or in the dining area. The dining area on Queen Marys was attractively set with good light. Tables were set with condiments and glasses and people could choose where they sat. People told us they could choose where they ate, "The staff always ask me where I would like to take my meals, alone or in the dining area." One person who ate in their room said, "I prefer it, it's what I want, I go down occasionally but it's nicer to eat here." Another person said, "I like sitting in my chair to eat, it's what I did at home." The food was well presented, people were offered condiments and were seen to enjoy their meals. Staff recorded amounts eaten of those who required monitoring and ensured people ate a healthy diet. Fresh fruit was offered at meal and drink times. We were also told that snacks were available during the evening and night if someone felt hungry. One staff member said, "The kitchen is always open we can access bread, cheese and soups." Visitors told us, "Food is nicely prepared, they get a lot of choice, in fact whatever they fancy." On Mulberry House people ate in the dining area of the kitchen. There were a variety of tables that were of varying height to accommodate people's wheelchairs. People told us that there was always plenty of choice. Some people had some comments about the menus which the chef was aware of and was in the process of auditing. The chef acknowledged that due to the wide age range it was a juggling act to ensure that everyone's preferences were reflected in the menus but said alternatives were always available.

Queen Marys and Mulberry House provided care and support to people with swallowing difficulties, for example following a stroke. For people assessed with a swallowing difficulty, the use of thickened fluids when drinking was required to minimise the risk of choking and aspiration. Thickened fluids are easier to swallow; however, the quantity and texture must be appropriate for the individual as otherwise they can place the person at risk of aspiration. Nursing staff were responsible for the management of thickened fluids and guidance was in place on the required texture of thickened fluids. Input from dieticians and speech and language therapists were also sourced. Guidance was readily available in people's care plans about any special dietary requirements such as a soft diet. One person's care plan had a report which identified they required a 'soft, moist diet'. We saw that this was followed. Staff informed us that this person was eating very little and their food intake chart reflected this. Staff told us of various ways they fortified people's food, "We use cream for soups and add cream to sauces, we make milk shakes as well."

People were involved in making their own decisions about the food they ate and were provided with options of what they would like to eat. A daily menu was displayed on notice boards throughout the building. If people did not like the options available, alternative meals could be offered. Information was readily available on people's dietary likes and dislikes and the chef had a firm understanding of people's dietary requirements. Where a need for a specialist diet had been identified, this was provided. For example some people were on a soft diet due to problems with swallowing. Some people were diabetic, and therefore reduced sugar food was available.

Staff understood the importance of monitoring people's food and drink intake and monitored for any signs of dehydration, weight loss and weight gain. Staff also recognised that if someone was refusing food or suffering weight loss, it may be associated with a health or swallowing problem. Weight gain can be caused by anti-psychotic medication and staff monitored people's weight carefully when prescribed.

Good

Is the service caring?

Our findings

The home had a relaxed atmosphere and people responded to staff as they approached them in a kind and dignified way. People nodded and smiled when asked if staff were kind and caring. Relatives felt staff offered the care and support people needed and wanted. One relative thought the staff were, "caring and kind" and "Always cheerful and ready with a smile." Staff told us they spent time with people and didn't try and rush them to get everything done. One staff member said, "We always provide the care people need when they want it, it's always at their pace."

People were treated with kindness and respect, as individuals, and it was clear from our observations that staff knew people very well. Staff made eye to eye contact as they spoke quietly with people; they used their preferred names and took time to listen to them. Staff knocked on people's bedroom doors before they entered, saying "Morning (name)" and, "You are looking fine today." We saw several lovely interactions, staff used affectionate terms of address and gentle physical contact as they supported people, and people responded with smiles. We also saw a care staff member sit with a person during a late breakfast and encourage them with eating independently with gentle prompting, "Would you like me to get you a teaspoon, it might be lighter for you" and, "Shall I help you with the last bit, it can be difficult." This enabled the person to retain their dignity whilst accepting help. The SOFI told us that staff and people engaged positively using verbal and non verbal communication.

People were consulted with and encouraged to make decisions about their care. They also told us they felt listened to. A relative told us, "They ask us for suggestions and keep us well informed". Staff supported people and encouraged them where they were able to be as independent as possible. Another relative said, "X (name) doesn't have capacity to make decisions, but the staff encourage him to make choices." The manager told us, "People can do what they want when they want."

People's preferences were recorded in the care plans and staff had a good understanding of these. There was information about each person's life, with details of people who were important to them, how they spent their time before moving into the home, such as looking after their family or employment, hobbies and interests. Staff said they had read the care plans and told us each person was different, they had their own personality and made their own choices, some liked music and noise while others liked to sit quietly, and they enabled people to do this as much as possible. People chose how and where they spent their time. People, who wanted to sit and read, rather than participate in activities, were supported to do so.

People's privacy and dignity was protected when staff helped them with personal care and bedroom doors remained closed as people were assisted to wash and get up. We saw staff encouraged one person to return to their bedroom to change, although they wanted to remain in the lounge, staff spoke quietly with them, encouraged them and they agreed to change their clothes. Staff told us, "People need a lot of support with their personal care and we keep in mind at all times that some things are very private. We would not like everyone to know that we had had an accident and our clothes were wet and needed changing. We just need to imagine how we would feel if it was us or a relative." This showed staff understood the importance of privacy and dignity when providing support and care.

Staff promoted people's independence and encouraged them to make choices. We saw that those people who liked to move around independently were supported discretely by staff. Staff talked to people and asked them if they needed assistance, they explained to people what they were going to do before they provided support and waited patiently while people responded. One staff member said, "Shall I help you to the table, its lunchtime soon." They leant down to talk to the person face to face so they could see their expression, and waited until the person responded. Comments from staff included, "We encourage people to be independent as they can be. I don't interfere if I think someone can do something for themselves," and, "I like to get people to make their own decisions if they can. For example, if someone doesn't want to do something then we make sure we offer later." People confirmed that staff involved them in making decisions on a daily basis. One person said, "I do get frustrated when I can't explain what I want but staff are really patient and wait, they don't make presumptions."

People's equality and diversity needs were respected and staff were aware of what was important to people. People were encouraged to be themselves. One person said, "I know that I can express myself and staff will support me." Another person liked to look smart and told us staff ensured that their clothes were clean and pressed, another person told us, "I like to wear make-up especially if I am going out, I can't do it myself but staff help me."

Staff said relatives and friends could visit at any time and relatives told us they were always made to feel very welcome. One relative told us, "We are always welcomed and feel at home, tea is always offered. We know all of the staff."

The communal lounges provided the feel of being at home, comfortable chairs were available and books, videos and DVDs were displayed for people to use at any time. A selection of good size communal areas were available throughout the home. These included a quiet lounge with a bar, television room and conservatory. People were seen enjoying spending time in different areas with family and friends. Mulberry House also had a gymnasium room people used for planned sessions with the physiotherapist and for exercise sessions as and when they wanted to. Outside areas were available and assessable for everyone. There were areas for people to be involved in growing vegetables and flowers and to sit and enjoy the fresh air.

Care records were stored securely in the staff offices. Information was kept confidentially and there were policies and procedures to protect people's confidentiality. Staff had a good understanding of privacy and confidentiality and had received training.

The home had a strong ethos of promoting people's independence and individuality. Staff could clearly tell us how they enabled people to remain independent. For example, one person told us how they managed their own finances, another of how they were getting stronger and doing their own personal care. The manager and staff worked in partnership with healthcare professionals on the staff team such as OT's and physiotherapists to help keep people mobile and independent. Care plans evidenced people were encouraged to meet personal goals to regain and increase independence in maintaining their personal care and in mobility.

People were able to express their views and were involved in making decisions about their care and support and the running of the home. Residents' meetings were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. We saw that ideas and suggestions were taken forward and acted on. For example, menus. Information on the use of advocacy services was available and the manager confirmed the home worked in partnership with Independent Mental Capacity Advocates (IMCA) when required.

Good

Is the service responsive?

Our findings

People liked their rooms and had individualised them with colour schemes, memorabilia, photographs and personal possessions with the assistance of relatives and friends. Relatives said they were involved in discussions about and the planning of people's care and felt able to talk to the staff about this at any time. One relative said, "I know there is a care plan and I get asked regularly for my input." Another relative said, "I am informed of any changes and if my relative is unwell the staff ring me."

At the last inspection the registered provider had not ensured that people's individual needs were met. People's needs had been assessed before they moved into the home and the previous care plans had been developed from this information. This inspection found that staff had reviewed this information and updated it with the help of relatives, friends and representatives. Each care plan looked at the person's individual needs, the outcomes the support and care aimed to achieve and the action staff had taken to achieve this. For example, one person's need was assistance with mobility. The outcome was for staff to ensure their walking aids were always near them and that their footwear was correctly fitted for maximum support. We saw that staff followed these care directives. Another person who lived with diabetes had guidance within their care plan of how to respond if their normal blood sugar varied and what action to take. For example if their blood sugar was lower than their normal range, staff were to give a glass of milk or a biscuit and to retake their blood sugar. This meant that care delivery was responsive to people's individual needs.

The care plan format had changed since the last inspection. This was undertaken to provide staff guidance to follow with a more person centred approach. Staff said they found the new care plans much easier to use, people's needs had been clearly recorded and they felt they could provide the care and support people needed if people were unable to tell them. One staff member told us, "We look at the care plans and if there are any changes we will update the record." Our observations during the inspection confirmed that staff did this. Although we found some gaps and care plans had not been updated as people's needs changed, although the staff were aware of the changes and the support people needed. This is an area discussed with the manager as one for improvement.

Staff said, "We have a handover at every shift change which is really helpful. We discuss people and changes that have happened, if someone is poorly or unhappy." The purpose of the daily meeting was to review the care and support provided over the previous 24 hours and to share knowledge and developments with a view to maintaining high standards of care. The meeting was conducted in an open and inclusive manner and all staff were invited to share their observations and opinions. The discussions were focused on people's care needs with clear plans of action drawn up following the meeting. For example, people's dietary needs were reviewed and potential issues discussed and action agreed. One person was having antibiotics to treat an infection. The team discussed the care of this person and the need for extra fluids to be taken at this time and for closer observation until the person has recovered, with fluids recorded so they had a record of how much the person had consumed. We looked at a selection of these and found they were clearly focused on the care needs of people living at the home. This meant that staff had a good understanding of people's support needs.

The support and care provided was personalised and based on people's preferences. An activity programme was displayed on the notice board, which staff said was really just suggestions for people to think about joining, it's very much down to people's choice. A number of activities were provided throughout the inspection and these varied depending on what people wanted to do. People sat around a dining table, some were supported to do craft work and talked together and with the activity staff, whilst some people observed what they were doing. They were relaxed and comfortable together and smiled and laughed at the suggestions made by staff. Everyday a person chose the background music for the lounge areas. The activity person said they spent time with people who remained in their rooms and we saw also them talk to people sitting in the lounge. Conversations were relaxed and friendly, people responded when spoken to and there was a considerable amount of smiling and laughing. The activity programme was varied and there was positive feedback from people about themed meals, entertainers and visiting animals. It was noted that people from Mulberry House did not have their own activities in their building at this time but were able to join in the activities on Queen Marys.

One staff member said, "We have some time to sit and talk to people, but often it is when we are supporting them during meals, but it is still chatting about something that is not about the care they need which is important."

A complaints procedure was in place; a copy was displayed on the notice board near the entrance to the home, and given to people and their relatives. Staff told us they rarely had any complaints, and the manager kept a record of complaints and the action taken to investigate them. The complaints folder contained one recent complaint. People told us they did not have anything to complain about, and relatives said they had no concerns and if they did they would talk to the manager, provider or the staff.

The provider and manager wanted to encourage feedback from relatives and friends and had arranged relatives meetings. We looked at the minutes from the meetings held throughout 2015. It was clear the staff were quite open about what was happening in the home, including the changes to staffing, and relatives were encouraged to raise any concerns. The meetings provided an opportunity to discuss any issues they had, and the minutes seen contained a plan to decide what action would be taken as a result of the meeting, by when or by whom. This was an area that was continuously improving.

Good

Is the service well-led?

Our findings

From our discussions with relatives, staff, the manager, the provider and our observations, we found the culture at the home was open and relaxed. Care and support focused on providing the support people living at Queen Marys and Mulberry House needed and wanted. Relatives and staff said the manger was available and they could talk to them at any time. We observed the manager greeting and sitting with people and talking to them at various times throughout our inspection. Relatives said the management of the home was good and staff were always very helpful. One relative said, "The home is well led, clean and calm." The manager took an active role within the running of the home and had good knowledge of the staff and the people who lived there. There were clear lines of responsibility and accountability within the management structure. The service had notified us of all significant events which had occurred in line with their legal obligations.

At the last inspection we found the provider did not have an effective monitoring system in place to protect people against inappropriate care and support. We found these concerns had been addressed.

Quality monitoring systems had been developed and sustained. A number of audits had been introduced and other audits developed, including for care plans, which had identified that additional training and support was required to ensure care staff updated the care records when people's needs changed. Medicine audits looked at record keeping and administration of medicines and the manager said action would be taken through the supervision process if issues were identified. Staffing levels had been reviewed, and a recognised tool was used, and an active recruitment programme was in place.

Whilst care staff told us that they felt communication in the home was really improving and that they felt supported, RNs had concerns about recent changes to staff deployment. From discussion with both RNs and the management team, it seems that there was some miscommunication about the staff changes which was causing RN's to feel unsafe in their role. The management team informed us that it was for a trial period only and would be discussed with all staff before a decision made. We were told that this would be addressed immediately with staff.

Systems for communication for management purposes were well established and included a daily meeting with the senior staff. These were used to update senior staff on all care issues any management messages. For example, discussion around who had fallen and what risks had been identified. Staff felt they could feed into these meetings. One staff member said, "What's good is the manager is open to suggestions, carers (give information to the nurses) who have a daily nurses meeting and during staff meetings issues are raised and acted on." Each shift change also had a handover meeting so staff changing shifts shared information on each person. A handover sheet given to staff facilitated this process with key aspects of care being recorded. The service worked in partnership with key organisations to support the care provided and worked to ensure an individual approach to care. Visiting health care professionals were positive about the way staff worked with them communicated with them and ensured advice and guidance was acted on by all staff.

Staff told us they were involved in discussions about people's needs and were encouraged to put forward suggestions and opinions during the daily meetings and the monthly staff meetings. Staff said, "We are encouraged to be involved in developing the service here." "I think the management is strong and approachable." and, "I feel sure that if I speak to the manager about anything, something will be done about it, I don't just mean complaints suggestions are encouraged as well and they listen to us.

Since the last inspection the manager had successfully submitted her application to be registered with CQC, but the process was not yet completed. The manager is a registered nurse and continues to work alongside staff delivering care as required. This was appreciated by staff and people. One staff member said, "We can rely on the manager to assist us when we need it, her knowledge is welcomed."

The management team have been working consistently to develop the support and care provided at the home. From their reports we saw a record of some of the improvements we identified, such as the care plans and staff recruitment as well as areas for further improvements, with action plans to address them. The manager said, "Whilst we feel we have really improved, we want to continue to improve to deliver really outstanding care."

Relatives felt they were able to talk to the manager and staff at any time and the relatives meetings provided an opportunity for them to discuss issues and concerns with other relatives, friends and management on a regular basis. One relative said, "If I have a problem I just talk to the staff or manager and they deal with it."

Staff spoke of the home's vision and values which governed the ethos of the home. Displayed in areas of the home was a value statement that staff were proud of. The ethos of the home was embedded into how care was delivered and the commitment of staff to provide high quality care and person specific care. The manager and staff had a strong emphasis on recognising each person and their identity. Staff wanted to provide care that was individual to that person and it was clear staff recognised each person in their own entity. From observing staff interaction, it was clear staff had spent considerable time with each person, gaining an understanding of their life history, likes and dislikes. Care was personal to each person and staff clearly focused on the individual and their qualities.