Galleon Care Homes Limited

Queen Mary's and Mulberry House Nursing Home

Inspection report

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Ratings

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

Overall summary

We inspected Queen Mary's and Mulberry House Nursing Home on the 29 January and 02 February 2015. 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 48 people living at Queen Mary's and 14 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

Summary of findings

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. The manager had just completed her probation period as 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.

At the last inspection in May 2014, we found they had met all the essential standards inspected.

People spoke positively of the home and commented they felt safe. However we found that people's safety was being compromised in a number of areas. For example, not all people who lived with epilepsy had a care plan to manage their epilepsy and seizures. There were no triggers identified for staff to react to and manage safety. Specialised equipment for peoples' very complex needs had not been checked or evidenced regular servicing to ensure it was working and safe. We also found that people were not fully protected from the risk of cross infection whilst receiving care.

Whilst people were able to make decisions about what they wanted to eat and drink and were supported to stay healthy, there was little evidence of health promotion initiatives around the home for people to see or even know about. Such as smoking cessation or mental health advice.

Quality assurance systems whilst in place had not identified the shortfalls found in care plans or in the maintenance of the specialised equipment used for people. Despite concerns with the provider's quality assurance framework, people received care that met their needs in a personal and individual manner. However, we have identified the above as a breach of regulation 10.

People were cared for, or supported by, sufficient numbers of suitably qualified and experienced staff. Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

Training schedules confirmed staff members had received training in safeguarding adults at risk. Staff knew how to identify if people were at risk of abuse or harm and knew what to do to ensure they were protected.

People's medicines were stored safely and in line with legal regulations. People received their medicines on time and from a registered nurse.

Staff understood the principles of consent and respected people's right to refuse consent. All staff had received training on the Mental Capacity Act 2005 (MCA) and mental capacity assessments were consistently recorded in line with legal requirements.

People had a care plan which outlined their needs and the support required to meet those needs. Care plans were personalised and included information on people's individual likes, dislikes, daily routine and what was important to that person.

Accidents and incidents were recorded appropriately and steps taken by the service to minimise the risk of similar events happening in the future. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

People were treated with respect and dignity by staff. They were spoken with and supported in a sensitive, respectful and caring manner.

People felt well looked after and supported. We observed friendly and genuine relationships had developed between people and staff. People were seen laughing and smiling with staff. Staff understood the importance of monitoring people's health and well-being on a daily basis.

Summary of findings

Staff received on-going training and support which enabled them to provide effective care. Staff spoke positively of the manager and demonstrated a commitment to providing good quality care.

There were opportunities for additional training specific to the needs of the service. This included care of the tracheostomy, speech and communication strategies and the management of acquired brain injuries. Staff had received regular supervision meetings with their manager, and formal personal development plans, such as annual appraisals, were in place.

There was a multi-agency approach to care delivery that was essential to meeting a range of complex needs. There was input from physiotherapists, psychologists and occupational therapists that ensured all aspects of care delivery were explored. Activities were meaningful to people and promoted their identity and self-worth. Staff regularly took people out to local shops, cafes and for outings. People's lifestyle choices and diverse social and cultural needs were maintained and supported.

Feedback was regularly sought from people, relatives and healthcare professionals. The manager and staff continually strived to make improvements and deliver care that was personal to each person.

Staff told us about the home's vision and values statement. The provider had mechanisms to assess the effectiveness of care plans. People received care which met their needs in a personal and individual manner.

We found a number of breaches including continuing breaches of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Queen Mary's and Mulberry House Nursing Home was not consistently safe. Specialised equipment had not been serviced or checked regularly and therefore did not ensure safe care. People were not protected from the risk of cross infection whilst receiving care.

Risks to people's safety from health related problems such as seizures had not been identified by the staff and measures had not 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?

Requires Improvement

Queen Mary's and Mulberry House Nursing Home was not consistently effective. Whilst people were able to make decisions about what they wanted to eat and drink and were supported to stay healthy, there was little evidence of health promotion initiatives around the home for people to access on their own initiative. This did not promote people's independence in decision making. Such as smoking cessation or mental health advice.

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.

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

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.

Summary of findings

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?

Requires Improvement

Queen Mary's and Mulberry House Nursing Home was not consistently well-led. The home's quality assurance framework required improvement as mechanisms were not in place to analyse or monitor the effectiveness of their own systems. For example, equipment checks had not 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 care delivery within the home, striving for excellence.

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 28 January and 02 February 2015. 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, eight visiting relatives, six care staff, two registered nurses, two occupational therapist assistants, one occupational therapist, the cleaner, the manager and a visiting GP.

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 Nursing Home. Relatives confirmed they felt confident in leaving their loved one in the care of the home. One relative told us, "I never worry about things, they are very good here." Another relative said, "I trust the care staff, there is a good number of good staff to meet his needs. The small service makes life here more like a family." One person told us, "I feel safe and I trust my care workers." However we found there were shortfalls which compromised people's safety and placed people at risk from unsafe care.

People's safety was not ensured as specialised equipment for specific health needs was not regularly serviced or checked. The equipment for the highly dependent and complex needs of people had not been serviced or had a portable appliance test (PAT) within recommended timeframes: PAT Testing is the process of checking electrical appliances for safety. The suction machine had been due for a service in October 2014. This had not been undertaken. The enteral feed pump and portable suction machine was last PAT tested November 2013. The humidifier and oxygen concentrator had no PAT or service dates on machine and staff could not produce the service dates. This equipment was in constant use and imperative to the safety of the people who used it, for example choking and aspirating which would lead to serious chest and lung complications.

The emergency equipment trolley was not fully equipped and ready for use. For example, the suction machine was not ready for use, it was dusty and there was no record of its last check by staff or PAT test. If someone was choking and their airway blocked, this machine would not be readily available and therefore would compromise people's safety. We spoke with staff about the organisational procedures for a medical emergency. They referred to the emergency trolley for use in an emergency, "We have a trolley outside the office for use if someone was choking or unwell." We asked who was responsible for checking emergency equipment and trolley, but staff were not sure who was responsible or if there was a check list. This meant staff could use equipment in an emergency which was unsafe or not working, placing a person at risk. We could not be assured that equipment used by staff to meet the individual complex health needs of people were serviced, checked and safe.

The above issues were a breach of Regulation 16 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home was clean and hygienic. The organisation had an infection control champion and organisational policies and procedures for reducing the risk of infection. Staff told us of protective equipment available in the home such as gloves and aprons to prevent cross infection. They confirmed they had training on a regular basis. However we observed staff were not following Infection Control procedures according to best practice or current guidance whilst providing care for maintaining a clear airway for breathing for a person with very complex health needs. On three occasions suction treatment was performed and we observed this to be done without the use of gloves or aprons and no hand washing before or after the procedure. This person had had recent chest infections and therefore presented as a risk of cross infection and was also at risk from cross infection. We asked why staff were not following good practice infection control guidelines and were told that all staff had received specific training and this would be addressed immediately by further training and supervision.

We also observed staff still wore the same gloves and aprons after completion of personal care whilst moving around the home and moving people in to communal areas. This placed people at risk from cross infection. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risk assessments for health related needs were in place, such as skin integrity, nutrition, falls and dependency levels. However we found two care plans for people with epilepsy did not have guidance in their respective care plans of the management strategies required. There was no evidence of a seizure care plan for one person who was taking anti-epileptic medication and had a long history of epilepsy. This person had no way of notifying staff of any specific signal indicating a seizure was imminent. History and knowledge of triggers were not documented. The other person was a recent admission and the staff on-duty were

Is the service safe?

unaware that this person was on medication for epilepsy and there was no guidance for staff on how to manage the person in the event of a seizure or a health problem that might affect the effectiveness of medication.

We asked the manager how people with epilepsy were managed when going out in terms of seizure plan and rescue medication. The manager said there were no plans, the care staff with them would have to call 999. This did not promote the safety of those people.

One person's records contained photographic evidence of a high grade pressure sore to their heel. There was no supporting care plan to manage this sore. The existing care plan was written and reviewed before and after this sore had been identified in November 2014 & January 2015. However there was no reference to this sore at all in the care plan and no follow up photographs. The manager checked on our visit day and the sore was now healed. The manager said they would put on-going preventative measures in place as the person's skin integrity assessment did not reflect the presence of a recent heal sore and the person's vulnerability to this happening again had not changed.

The planning and delivery of care had not ensured people's individual needs had been met and had not ensured their safety. These issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were supported to live an independent live style as far as possible despite living with a wide range of illnesses such as, an acquired brain injury, dementia, Parkinson's and diabetes. This was very important for people living in Queen Mary's and Mulberry House Nursing Home due to the fact that some people living there may in the future go on to supported living accommodation. The registered manager and staff understood the importance of risk enablement, this meant measuring and balancing risk. A staff member said, "To live a full life as possible people should be able to take risks and we encourage people to take risks whilst ensuring they are as safe as possible." 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, help with cooking 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.

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, sexual relationships or having an alcoholic beverage.

Staff told us what they would do if they suspected that abuse was occurring at the home. They were able to tell us who they would report safeguarding concerns to outside of the home, such as the Local Authority or the Care Quality Commission. It was clear from discussion staff understood their own responsibilities to keep people safe from harm or abuse. Safeguarding policies and procedures were up to date and appropriate for this type of home in that they corresponded with the Local Authority and national guidance. There were notices on staff notice boards to guide staff in whom to contact if they were concerned about anything and detailed the whistle blowing policy. 'Whistleblowing' is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest.'

Medicines were managed safely. People told us they received their medicines on time and visiting relatives commented they felt assured in care staff managing their relative's medicine regime.

Medicines were ordered in a timely fashion from the local pharmacy and Medication Administration Records (MAR charts) indicated medicines were administered appropriately. MAR charts are a document to record when people receive their medicines. Records confirmed medicines were received, disposed of, and administered correctly. We also observed three RN's administer medicines safely and following good practice guidance. Guidance was in the place for the use of, as required medicines (PRN). PRN medicine should only be offered

Requires Improvement

Is the service safe?

when symptoms are exhibited. Documentation provided information on when the PRN medicine should be offered, the maximum dosage, reasons for giving, steps to take before giving the medicine, actions after giving the medicines and the expected outcome.

Sufficient numbers of skilled and experienced staff contributed to the safety of people who lived at the home. Mulberry House and Queen Marys Units were staffed separately. Throughout the inspection, we observed people received care in a timely manner and call bells were answered promptly. Staffing levels allowed for staff to support people and to take people outside for regular cigarettes. Staff on Queen Mary's, told us more staff in the afternoons would enable them to spend quality time with people, one staff member said, "I think we should be able to spend at least half an hour a day just sitting with each person, it's doesn't happen often enough." We discussed this observation with the manager and area manager. We were told that this is an action point they have already identified, staff recruitment was underway to address this, but they didn't fell using agency staff was in the best interests of their residents." The manager said, "Safety is paramount and we ensure that staffing levels are sufficient to provide safe and good care."

Staffing levels were based on the needs of individuals. People and staff we spoke with commented they felt the home was sufficiently staffed. Two relatives told us, "Good amount of staff around," and "I think the staffing levels are good, I am here most days and not had any worries."

Recruitment processes were safe. Staff files confirmed that a robust recruitment procedure was in place. Files contained evidence of disclosure and barring service (DBS) checks, references included two from previous employers and application forms.

People were cared for in an environment that was safe. This does not include the specific medical appliances mentioned in the breach above. There were procedures in place for regular maintenance checks of equipment such as the lift, fire fighting 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. Mulberry House had PEEPs displayed on doors as many people had complex needs. Staff were able to discuss peoples PEEPS and how they would promote their safe evacuation. Staff had received regular fire training which included using fire extinguishers and evacuation training. We observed staff receiving this training during our inspection.

Requires Improvement

Is the service effective?

Our findings

People told us they received effective care and their needs were met. One person said, "This is now my home, a good place to be, I get the support I need," and another said, "I am very settled here, everything is very good, my life has improved with their care." A relative told us, "when my son had a red pressure mark recently the team were very quick to inform me and take action to prevent this getting worse, the same day a pressure relieving mattress had been put on his bed and a two hourly turning regime in place."

We found whilst people were supported to maintain good health and received on-going healthcare support, there was little evidence of health promotion initiatives around the home for people to see or even know about. For example, how to access mental health services, quit smoking courses or healthy eating. This meant independent decision making and keeping people informed of choices of lifestyle was not fully promoted. One person asked us if we knew of a self-help group for a particular problem they wanted advice for, and hadn't wanted to bother the staff, "I want to do this for myself." We asked staff if they could facilitate people attending self-help groups for various problems. Staff admitted that this had not been considered but would look into providing a notice board that people could find help lines and meetings as and when they needed without having to ask staff to assist. This is an area that requires improvement.

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 especially for those with multiple health problems such as epilepsy following a brain injury 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 supported with attending appointments.

Staff had received essential training in looking after people, for example in safeguarding, food hygiene, fire evacuation, health and safety, equality and diversity. Staff completed an induction when they started working at the service and 'shadowed' experience members of staff until they were found competent to work unsupervised. Two members of staff shared their induction experience with us, "It was thorough and I felt prepared to start working," another said, "Interesting and invaluable."

Staff also received training specific to peoples' needs, such as behaviour that challenges, care of people with an acquired brain injury, dementia and end of life care provided by a local hospice. Additionally there was specialist training for the care of tracheostomy (A **tracheostomy** is a surgical procedure to create an opening in the neck at the front of the windpipe to aid breathing), care of a percutaneous endoscopic gastrostomy (PEG) (which is a tube which is passed into a patient's stomach to provide a means of feeding when oral intake is not adequate), dementia and epilepsy training. 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 a staff member confidently and sensitively de-escalate a situation in the communal lounge. They reassured the person in a respectful and confident manner and used diversion tactics to de-escalate the situation successfully. We 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. All carers caring for a resident with a tracheostomy were tracheostomy competent. The therapy team provided skilled expertise in meeting people's care and handling needs most of which were complex. The psychologists supported the care delivery in identifying and supporting the people's emotional and psychological needs. We saw an example of effective care in that one person with a long standing tracheostomy had been successfully progressed to having a plug instead of the tube. This enabled the person to sample food and added to their quality of life.

Staff received ongoing 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 registered manager confirmed formal systems of staff development, including annual appraisal was in place.

Requires Improvement

Is the service effective?

The manager told us, "It's important to develop staff, we also want to train them and keep them motivated to continue to develop their caring skills. We now have staff sharing their skills throughout Queen Mary's and Mulberry House Nursing Home." The therapeutic care team are now integrated with care team, which has proved successful and of benefit to the people receiving care. For example, care staff have learnt how to help exercise contracted limbs whilst performing personal care.

People were complimentary about the food and drink. One person told us, "The food is lovely, no problems at all, very edible." Another person told us, "You have a choice; the second course is whatever you choose from the menu."

The main kitchen was situated in the Queen Marys building and prepared most of the meals. A recent development at Mulberry House had changed the way in the main midday meals were provided. For the week days the occupational therapy team (OT) and one care staff cooked the main meal in the unit involving people as they were able. Some people helped in choosing the meals, some benefitted from the sensory experiences and some people assisted with some cooking tasks. Three people who were able to eat orally told us they really enjoyed these meals as they had chosen them. They were home cooked and often had more flavour than those produced in the central kitchen. One person who was gluten intolerant was joking with staff about the gluten pastry being made as we chatted. This person was actively involved in the decisions about the meal choices.

Those people who are not able to eat orally had their nutrition managed by trained members of the care team. We saw accurate records in relation to prescribing, administration and the management of enteral feeding.

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. 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.

We spent time observing lunchtime in the communal dining areas and in other areas of the home. The dining areas were set attractively and welcoming. The cutlery and crockery were of a good standard, and condiments were available. Meal time was unrushed; staff interacted in a friendly manner and were aware of people's needs. Staff encouraged people to be independent, for example, showing them the cutlery and how to use the cutlery independently. People who required support with eating and drinking, were assisted in a dignified manner, with care staff interacting and supporting the person at their own pace.

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.

CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). The provider was meeting the requirements of DoLS. The manager knew how to make an application for consideration to deprive a person of their liberty should they not have the capacity to make certain decisions, and there is no other way to look after them safely.

There was clear evidence to suggest a good understanding of DoLS by the manager. People had applications made (or underway) for DoLS due to the restrictive nature of their conditions and care needs. The staff we spoke with understood the principles of the MCA and gave us examples of how they would follow appropriate procedures in practice. There were also procedures to access professional assistance, should an assessment of capacity be required. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. There was good evidence in the care plan of one person of gaining consent to routine care interventions as well more personal activities they wished to participate in.

We witnessed that care interactions were based on gaining verbal consent or at the very least explaining what was to be done before proceeding. Staff asked people with open questions and waited for verbal or non-verbal agreement before they moved them, changed their position or administered medication.

Requires Improvement

Is the service effective?

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documents reviewed were completed accurately with good documentation in regard to best interest. In one case, involvement of a cognitively able but non- verbally able resident, the DNACPR was supported by a coherently completed advanced decision document.

Good

Is the service caring?

Our findings

People and visiting relatives spoke highly of Queen Mary's and Mulberry House Nursing Home. One person told us, "Very caring, they understand." Another person told us, "I am very lucky to be here, very well cared for here." 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, "My husband doesn't have capacity, but the staff encourage him and take him to the lounge to join in the activities". The manager told us, "Independence is supported. People can do what they want".

People said they had their privacy and dignity respected. A relative told us, "The staff ensure my relative is always treated with dignity. They do everything because of the nature of their illness, they never rush, or forget that they are treating a person, they explain everything they are doing and ask if it is ok". A person said, "They are not only my support but my life line and chat about day to day activities. They include my family in my life here." Another person told us, "I cannot shower alone, but they ensure I have privacy and dignity as long as I'm safe." The manager added, "Staff have an understanding of privacy, dignity and human rights. We treat people as individuals; this is one of our values." All care interventions observed through the inspection were caring and respectful with appropriate humour and the correct and respectful use of names.

All people were dressed as they wished and had their hair well cared for. People were able to choose what they wanted to wear. Many of the ladies had who expressed the wish to wear makeup and have their nails painted were seen to have their wishes followed.

When care was being undertaken in rooms there was regular use of 'care in progress' signs on people's doors. People's preferences for personal care delivery were respected. We saw ladies who had asked that their personal care be delivered by female staff had female care staff. There was reminder notices on these people's doors for visitors and staff to see the nurse in charge before entering their rooms. One person said, "The staff have never let me down, I prefer female carers and I get them." People's personal and diverse lifestyle choices were respected and upheld. Personal relationships were supported and appropriately risk assessed. Staff ensured people's privacy during private times but had an agreed action plan if they required urgent assistance.

People had been involved in their care and support decisions as much as possible. People's care plans contained personal information, which recorded details about them and their life. This information had been drawn together by the person, their family or their representatives and staff. Staff told us they knew people well and had a good understanding of their preferences and personal histories. The care plans and risk assessments were individual and person specific. Staff told us, "People's likes and dislikes are recorded. Everyone has a right to be heard and that is something we promote and we get to know people well." All the people we spoke with confirmed they had been involved with developing their or their relative's care plans. One person with highly complex needs who was unable to communicate in any way had an Independent Mental Capacity Advocate (IMCA**)** who visited monthly to ensure that their best interests were being considered in meeting their care needs.

There was a friendly, safe and relaxed environment, where people were happy and engaged in their own individual interests, as well as feeling supported when needed. The atmosphere in the home was calm and relaxed, with a friendly and homely feel. Considerable thought had been used when designing the environment to promote people's wellbeing. Bedrooms were very personalised with photographs and personal effects. People had been encouraged to choose colours that they wanted to live with. One mother told us, "We are able to choose the colour of the paintwork in the bedrooms and of course bring in special things." The décor in rooms and communal areas were age related throughout the home.

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

Good

Is the service caring?

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.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were always made to feel welcome. The registered manager told us, "There are no restrictions on visitors". A visitor said, "I come in each day and the staff care about me as well. He is in safe hands".

The home had a strong ethos of promoting people's independence and individuality. The registered manager told us, "We want people to remain as independent for as long as possible." Staff could clearly tell us how they enabled people to remain independent. One staff member commented on how they promoted people to wash their own face and dress themselves independently. 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. Minutes from the last meeting in December 2014 confirmed people spoke about Christmas and what activities they would like to do and what they would like at the Christmas party. Relatives confirmed they felt their loved one was involved in their care as much as possible.

Good

Is the service responsive?

Our findings

People told us they were listened to and the service responded to their needs, both care and social well-being and concerns. There was regular involvement in activities and the service employed a full time activity co-ordinator who was mainly involved at Queen Mary's. The occupational therapy team at Mulberry House were responsible for planned activities and one – to- one session with people. One person at Queen Mary's told us, "I use the computer and I play music. I have four or five visitors per week." Another said, "We have takeaways and special themed evenings, all very good." Another person said, "My husband does not have capacity, but staff encourage him at every stage, even helping to do quiz sessions in the lounge". Activities were organised in line with people's personal preferences, for example, craft classes, music shows. We also saw a varied range of communal activities on offer, including, pet visits, quizzes, visits from singing groups, trips out to the local town and exercise to music sessions.

The home supported people to maintain their hobbies and interests. Records were kept on people's attendance and enjoyment of activities. On Mulberry House evidence in people's daily diary of a personalised timetable which included personal care with time preferences, activities and rest times. We saw they were well structured and contained information of regular visitors and trips out. We visited one person who wished to share with us how staff had enabled and supported them to be as independent as possible. This person was only able to use small head movements. Staff had supplied and supported this person to use a head control to operate their wheelchair and room environmental controls. This meant they were able to switch on the lights, work the TV & CD player by themselves. Part of their care plan was to increase their ability to 'drive' their electric wheelchair and daily 'lessons' were in place assisting with this skill. This person had also been supplied and taught how to use paintbrushes with the use of mouth controls. There were clear instructions for the care team in how to manage the mouth painting equipment particularly in relation to infection prevention; a trip to local art gallery was recorded which had inspired this resident with their painting. For those people who were not able to communicate verbally a letter recognition communication board had been developed, allowing the person to spell out each word, we observed staff were very patient and supportive when using this communication aid with people.

People at Queen Mary's told of a recent visit by a miniature pony, "Really lovely a real treat." A relative said, "Lots going on for my dad to do, he's happy here." Another person said, "I like to be left to my own devices and this is respected. I go down to the meals and I join in some of the quizzes."

Records showed comments, compliments and complaints were monitored and acted upon. Complaints had been handled and responded to appropriately and any changes and learning recorded. The procedure for raising and investigating complaints was available for people. One person told us, "If I was unhappy I would talk to the staff and management, they are approachable and will listen." The manager said, "People are given information about how to complain. It's important that you reassure people, so that they comfortable about saying things. I hope that people are confident to come to staff if they have concerns."

A service user / relatives' satisfaction survey had been completed in late 2014, and a further survey had been sent out to visiting professionals. Results of people's feedback had been used to make changes and improve the service. For example, meetings were held regularly for people at which they could discuss things that mattered to them and people said they felt listened to.

People received care which was personalised to reflect their needs, wishes and aspirations. Care records showed that a detailed assessment had taken place and people had been involved in the initial drawing up of their care plan. These plans also provided information from the person's point of view. They provided detailed information for staff on how to deliver peoples' care. For example, information about personal care and physical well-being, communication, mobility and dexterity.

Care plans were reviewed monthly or when people's needs had changed. In order to ensure people's care plans always remained current, a key worker system had just been introduced. A key worker is a member of staff who takes responsibility for the person's care and documentation and provides consistency to the persons care. This member of staff will be involved in reviews, in meetings and be identified to families. Daily records also provided detailed

Good

Is the service responsive?

information for each person and staff could see at a glance how people were feeling and what they had eaten. People were involved in the reviews of care, which were then checked and signed by them on completion. A relative told us, "I am involved in all reviews and I can change things and add things." We sat and discussed one person's care plan with them and they felt it was accurate and that they had been involved."

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff spoke well of the manager and felt the home was well-led. Staff commented that events in the past six months had been a learning experience. They felt they were supported and could approach the manager with any concerns or questions. Relatives and people said they felt communication had improved and there were systems in place to share their concerns. Despite people and staff praise and confidence for management, we found Queen Mary's and Mulberry House Nursing Home was not consistently well-led.

Arrangements were in place to monitor the running of the home and the effectiveness of auditing systems. These included welfare monitoring checks, health and safety audits, office inspection checks, health and safety monitoring and emergency procedure checklist. However, despite having these systems, the provider had not identified the shortfalls in care plans or in the equipment safety check lists. Therefore, there were no mechanisms in place to monitor, analyse and review the effectiveness of care plans or ensure that specialised equipment was fit for use and safe. The lack of quality assurance framework surrounding care plans meant that the provider and registered manager had also not identified epilepsy care plans were not in place. Therefore information was not available on the person's management of epilepsy, the signs and triggers of a seizure and what to do in the event of a seizure. The lack of checking of specialist equipment for those people with high complex needs who rely on the equipment to maintain their health places people at risk.

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

Staff said they felt well supported within their roles and described an 'open door' management approach. This meant that staff were encouraged to ask questions, discuss suggestions and address problems or concerns with management. There was a management structure at Queen Mary's and Mulberry House Nursing Home which provided lines of responsibility and accountability. A manager was in day to day charge of the home, supported by the provider and an area manager. The manager had completed her probation period as a manager and has submitted her application to be registered as manager with the CQC. In the absence of the manager, a trained nurse lead was always on shift and the home had an area manager who could also be contacted in the event of an emergency.

Management was visible within the home and the manager took a 'hands on' approach. The home had a strong emphasis on team work and communication sharing. Staff commented they all worked together and approached all concerns as a team. Where people's behaviours had changed or new issues arose, it was clear staff discussed things and collectively thought of ways to improve, make changes or manage behaviour changes. For example, the staff had identified problems at meal times and had changed the venue for meals for certain people. This had proved successful in that people's appetites were reported to be improving.

There were systems and processes to consult with people, relatives and healthcare professionals. Regular satisfaction surveys were sent out to people and their relatives, providing the registered manager a mechanism for monitoring people's satisfaction with the service provided. People were supported in completing questionnaires. Staff had sat with people and completed the questionnaires using communication boards, computers and by using eye blinks. This demonstrated they had explored various methods of receiving people's views on the care they received. The manager explained if they received any negative feedback she would meet with the individual or relative to see how improvements could be made. Staff commented they felt more involved in the running of the home and felt able to make contributions and express ideas. One staff member commented extra staff member would allow staff to spend quality time once a day with an individual, this was taken by the manager as an important contribution and they were recruiting for that purpose.

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

Requires Improvement

Is the service well-led?

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.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered provider had not taken steps to ensure that each service user was protected against the risks of receiving care that was inappropriate or unsafe by means of carrying out of an assessment of needs of each service user and the planning and delivery of individual needs. **Regulation 9 (1) (b) (i) (ii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of service users and others. **Regulation 10 (1) (a) (b)**

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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered provider had not ensured that each service user was protected from the risk of cross infection whilst receiving care delivery. **Regulation 12 (1) (a) (b) (c) (2) (b) (ii) (iii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

This section is primarily information for the provider

Action we have told the provider to take

Diagnostic and screening procedures Treatment of disease, disorder or injury	The registered person had not made suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment by ensuring that equipment provided was properly maintained and suitable for its purpose. **Regulation 16 (1) (a) (4)**