Care Quality Commission

Tollgate Healthcare Limited

Mary Rose Manor

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

Mary Rose Manor is a nursing home registered to provide accommodation, nursing and personal care for up to 50 older people some of whom live with dementia. It is also registered to provide care to people with a physical disability, sensory impairment or mental health diagnosis. Accommodation is arranged over three floors with two lifts and stair access to each floor. There is a garden to the rear of the service. At the time of our inspection 46 people were accommodated.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

The service was run by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
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At this inspection we found the service remained Good.

Processes, systems and practices were in place to protect people from the risk of abuse. The registered manager ensured staff learning took place following incidents. Risks to people had been assessed and their safety was monitored. Processes were in place to ensure people's medicines were managed safely. People were protected from the risk of acquiring an infection.

There were sufficient suitable staff to meet people's needs. Staff pre-employment checks had been completed and the registered manager took swift action to ensure five staff without a full employment history as legally required, provided this information.

People's care was delivered in accordance with current legislation, standards and evidence-based guidance to achieve effective outcomes. Staff were appropriately supported in their role through training, supervision and professional development. People were supported by staff to eat and drink sufficient for their needs. Staff worked together to deliver people's care and ensured they were supported to access healthcare. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff treated people with kindness, respect and compassion and provided any emotional support they needed. People were supported to express their views and to be actively involved in decisions about their care where possible. Staff ensured people's privacy, dignity and independence were promoted.

People received individualised and responsive care that met their often complex needs. Staff provided

people with sufficient opportunities for stimulation and support to pursue their interests. People were supported appropriately at the end of their life.

People's care was underpinned by a positive person-centred culture. Staff understood their roles and responsibilities and regulatory requirements were understood and met. People's views on the service had been sought and acted upon. Processes were in place to ensure continuous learning took place and areas of practice that could be improved for people were identified and addressed.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

Care Quality Commission

Mary Rose Manor

Detailed findings

Background to this inspection

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

This comprehensive inspection took place 17 December 2018 and was unannounced. The inspection team included two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Prior to the inspection we received feedback from the local clinical commissioning group and the local authority safeguarding team. During the inspection we spoke with nine people and 14 people's relatives and a visiting doctor. We also spoke with day and night staff, which included two nurses and four care staff. In addition, we spoke with a chef, housekeeper, the administrator, the clinical lead, the deputy manager and the registered manager.

We reviewed records which included four people's care plans, five staff recruitment records, three staff supervision records, staffing rosters for the period 18 November to 23 December 2018 and records relating to the management of the service.

The service was last inspected in January 2017 and no concerns were identified.

Good

Is the service safe?

Our findings

People were protected from the risk of harm and abuse. People confirmed to us they felt safe in staff's care. Staff had undertaken relevant training and understood their responsibilities with regards safeguarding people from avoidable harm and abuse. Staff told us they were confident that concerns raised would be acted upon by the registered manager and assistant managers. Records demonstrated the registered manager had taken relevant actions to keep people safe and had made referrals to the local safeguarding team as required. Staff were provided with feedback on the outcome of safeguarding referrals and other incidents through meetings and reflective practice sessions. To support their learning and to ensure the risk of repetition was reduced for people.

Potential risks to people had been identified and controls were in place to minimise the risk of their occurrence. People's risks had been assessed for example, in relation to their, mobility, falls, behaviours, choking, health conditions, weight, skin care, smoking and medicines. Staff had a good understanding of the risks to each person and what they should report. If people required equipment to keep them safe this had been provided, where they required regular checks upon their welfare or re-positioning to prevent their skin breaking down, records showed this had been completed. Processes were in place to ensure incidents were documented, reviewed and evaluated to identify if any changes were required in people's care. There was evidence people had been consulted about how they wanted potential risks to them to be managed. This was empowering for them and ensured their views were heard.

The service had a business continuity plan in the event of an emergency. Relevant safety checks had been completed on utilities and equipment to ensure they were safe for use.

The registered manager used a dependency tool to assess staffing requirements. People and staff told us there were sufficient staff. A person said, "I ring my bell and help usually comes quite quickly." The nursing staff were a mixture of general, mental health and learning disability nurses. This ensured there was a good mix of skills amongst the nursing staff to meet people's often complex needs. Where the registered manager needed to use agency staff to cover staff vacancies and absences, they used the same agency for continuity.

Staff recruitment checks had been completed. These included, proof of the applicant's identity, references, fitness to work and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Two staff whose files we reviewed had not provided a full employment history. We brought this to the registered managers attention who took immediate action to address this, they also identified three other staff who needed to provide this information. Following the inspection evidence was provided these staff's employment history had been obtained to ensure this information was available as legally required.

Staff who were responsible for administering people's medicines had undertaken relevant training which they updated regularly and their practical competency at administering medicines was assessed annually as required. Staff had access to the provider's medicines guidance if required. People's medicines were

ordered, stored, administered and disposed of safely. Processes were in place to ensure the safe management of 'controlled' medicines which require a greater degree of security. Staff ensured people's medicine administration records were completed once their medicines had been dispensed to provide an up to date record.

Staff had undertaken training in infection control and food hygiene. They had access to plentiful supplies of gloves and aprons which they wore when they delivered people's care. Staff had access to colour coded laundry bags to minimise the risk of cross-infection for people. The building was well maintained, clean and fresh. There were sufficient housekeeping staff deployed to ensure it was kept clean.

Good

Is the service effective?

Our findings

People's needs were assessed prior to their admission to the service, to ensure their needs could be appropriately met. People's care was delivered in accordance with current legislation, standards and evidence-based guidance to achieve effective outcomes. For example, where people lived with diabetes they had clear care plans that outlined the actions staff should take if their blood sugar levels went too high or too low and identified the person's 'normal' blood sugar range, which can differ between people. Staff used recognised local and national tools to enable them to assess and manage potential risks to people and their welfare post any falls. Staff kept themselves up to date with best practice through their nursing registration revalidation processes, attending local forums, national guidance and the dissemination of learning and training within the team.

Staff completed an induction when they commenced their role which encompassed the provider's required training. They were then supported to undertake further training relevant to their role, for example, nurses undertook training in various clinical skills such as catheterisation and the use of a syringe driver which provides a supply of a medicine continuously. Care staff were encouraged to undertake professional social care qualifications. One relative told us staff had the skills to meet their loved one's complex needs. A visiting doctor confirmed the quality of clinical care people received was very good. Staff received regular supervision and an annual appraisal of their work, to ensure they were appropriately supervised in their role.

The chefs received information about people's food preferences when they moved in. People were offered choices of foods for each meal and alternatives were provided for those who did not like what was on the menu. We saw people were provided with generous portions of home cooked meals. People's dietary needs were met, for example, pureed meals were provided for people if required and those at risk of losing weight had their food fortified and additional snacks were provided such as milkshakes. A person said, "Oh yes, the food is great, I have special food not on the menu. They are great to cater for my tastes." Staff were provided with guidance about people's fluid requirements and documented and monitored people's intake. Any risks to people associated with eating or drinking had been managed and staff supported people as required.

Staff understood their responsibility to report any issues and had access to bleepers and walkie talkies to ensure issues could be escalated promptly for people. Nurses ensured referrals were made to external agencies as required and any relevant information provided. Staff monitored people's health and referred them to health and social care professionals as needed.

The service had wide corridors which were suitable for wheelchair users. One of the two lifts was large enough to accommodate a stretcher which was more dignified for people who required this care. People living with dementia were able to explore their environment safely, as it was uncluttered. There was adequate signage for people's bedroom doors and bathrooms. Although there was no directional signage we saw people were either able to orientate themselves at their pace or required full staff support when they mobilised. There were quiet spaces for people on each floor and the ground floor lounge bi-fold doors opened out onto the garden.

People's consent to care and treatment had been sought in line with legislation and guidance. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. Staff had undertaken relevant training and where required Deprivation of Liberty Safeguards were in place. Staff had ensured where people were deprived of their liberty, any restrictions in place were the least restrictive possible to protect people's human rights.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion by staff. A person told us, "The staff here are lovely, I get on with them all." A relative confirmed, "I am comforted by the fact that I know [loved one] is so well cared for." We saw staff were observant to changes in people and patient when they interacted with them. For example, a person tried to get up out of their chair and staff quickly responded to assist them. Staff made eye contact with another person and then gently touched their hand to ensure they had gained their attention before they tried to speak with them. Most people reacted positively to interactions from staff and clearly trusted them. Some people exhibited quite challenging physical and verbal behaviours, but we saw staff always remained calm and relaxed with them. Staff quietly tried to engage them and if the person did not want to engage at that time, they respected their wishes and withdrew, before approaching them again or asking a colleague to try.

We observed that across the course of the inspection staff provided people with choices about how and where their care was provided. At lunchtime on the middle floor we noted most people chose to eat in the lounge, but staff still laid tables up in the dining room to act as a visual prompt for people and to provide them with a choice of where to eat. There were sufficient staff rostered to ensure staff did not rush people to make decisions but had sufficient time for them.

Staff understood that people had to be actively involved in decisions about their care whenever possible and that it was their right to make choices. A staff member told us, "We ask people do you want a wash?" and, "You are not allowed to get people up before they are ready." Staff respected people's choices. For example, one person did not want to be checked upon at night, and this had been agreed with them and documented for staff's guidance.

Staff were observed to speak with people in a polite and dignified tone. People's care needs in relation to upholding their privacy and dignity were documented in their care plans. Staff were able to tell us how they made sure they protected and maintained people's privacy and dignity. Staff gave examples, that included how they made sure they knocked on doors before they entered, made sure people were fully covered when they were supported with personal care and made sure others did not enter rooms when they provided people's care.

There was an open visiting policy and people were encouraged to have visitors whenever they wished. Visitors were able to stay and have a meal with their loved ones and several visitors were expected for Christmas dinner. There was a bedroom which relatives could use if they wanted to stay overnight. There were kitchenettes where visitors could make a hot drink. People's visitors were made to feel welcome.

People's care plans outlined which aspects of their care they could participate in, to ensure their independence was promoted. For example, whether they could feed themselves, or manage finger foods. There was also a record of any equipment they required to support their independence.

Good

Is the service responsive?

Our findings

Staff had received training in person centred care planning. People had comprehensive and holistic care plans that identified and addressed their physical, mental, emotional and social needs. Staff also considered people's needs related to their protected characteristics as defined by the Equality Act, for example in relation to their age, disability or mental health, when they planned the provision of their care.

Staff were able to gain instant access to information to inform the delivery of people's care on electronic hand-held devices, in addition to the information provided at staff shift handovers. People also had an electronic summary and 'fast facts' page, which provided key information such as significant risks to them and their fluid intake for the past 24 hours.

Staff had sought information about people's history, including their family and occupation to prompt conversation. For example, we heard staff talking to a person about a game and asking them if it was one they had played with their children. People's care plans documented their preferences about how they wanted their care delivered. A person's continence care plan noted what a private person they had been prior to the onset of dementia, to make staff aware of how difficult accepting this aspect of care was for them.

People's care plans demonstrated they had been involved in making decisions about their treatment and care wherever possible. A person said, "I get input into my care plan, "and a relative confirmed, "Yes, we've been involved in [loved ones] care plan and the manager does keep us regularly informed by phone which is nice too."

The service provided care to a diverse range of people, some of whom were living with dementia and others who had a mental health diagnosis or brain injury. Staff had undertaken additional training in both dementia and managing behaviours that can challenge, to ensure they could meet people's care needs.

The service ensured that people had access to the information they needed in a way they could understand it and complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Staff had identified and documented people's individual communication needs.

People were provided with a range of activities provided both by the activities co-ordinators and external entertainers. People were supported to maintain friendships and pursue their interests. A person said, "I've made several friends here." The service was located near to the shops and people who were able to access the community did so. A person confirmed, "I go out regularly."

The service had a complaints policy, a copy of which people were provided with and was displayed in the reception. No written complaints had been received but the registered manager told us they had an 'open door' policy. People and their relatives were encouraged to raise any minor issues with staff, so they could

be resolved before they became a complaint.

People and their representatives were asked for their views about their end of life care if they were ready to have these discussions and their wishes were documented. People had do not attempt cardiopulmonary resuscitation orders in place where they did not want this intervention, or it was not in the person's best interests. Nurses had undertaken a nationally recognised programme on the delivery of palliative care, to ensure they had the skills and knowledge to provide people's end of life care at the service where this was their choice. Staff ensured anticipatory medicines were in place for people's comfort during their end of life care.

Good

Is the service well-led?

Our findings

People's care provision was underpinned by a clear vision for the service. The provider's values were reflected upon with staff during supervisions. There was an experienced registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager maintained strong oversight of the culture of the service and staff behaviours and they were a clearly visible presence at the service. A relative confirmed, "The manager is very efficient and professional." Day and night staff told us they felt happy and proud to work for the provider. One staff told us, "it's got a good feel." Staff felt able to raise any issues which might impact upon the delivery of people's care.

There was a clear governance framework in place and staff at all levels understood their roles and responsibilities. There were senior nurses on each shift to lead and direct staff in their work with people. This included weekends if relatives needed to speak with senior staff. The registered manager ensured any statutory notifications of significant events at the service had been submitted to the Care Quality Commission as required. Processes were in place to ensure people's written and electronic records were stored securely.

Processes were in place to identify and monitor any potential risks to people. For example, the clinical lead had since April 2018 maintained a record and analysis of any incidents people had experienced including falls and the actions taken to reduce the likelihood of repetition. This enabled them to monitor any emerging trends or themes that required action for people's safety. For example, because of the monitoring, a sensor beam was now used in a person's room at night to detect when they got out of bed, so staff could check on their safety. They had also attended training in their role as the falls lead and were in the process of developing further in-house falls training for staff.

People's views were sought through quality assurance surveys. The results from the last one, completed in March 2018 and the actions taken by the provider to address issues raised for people were displayed in the reception. The provider also sought people's views through a communal suggestion box, internet reviews and resident's and relative's meetings.

There were processes in place to monitor the quality of the service and to identify potential areas for improvement. There was a comprehensive audit programme, linked to the Care Quality Commission's key lines of enquiry. This enabled the registered manager to review the quality of the service provided for people and to identify any potential areas that required improvement. They sent the provider a monthly report on the service, to keep them informed of any emerging, issues and the actions taken to address them. The provider also completed regular visits to the service to ensure they monitored the quality of the service provided.

The service had good working relationships with external organisations, which included the safeguarding

team, clinical commissioning group and multidisciplinary teams, to ensure people received joined up care. The service also had links with higher educational establishments. They had participated in a national safety study, which looked at falls in nursing homes. They had also offered nursing placements to student nurses to enable them to develop their skills and knowledge. In addition, there were links with the local schools and on the day of the inspection local schoolchildren visited to sing Christmas songs for people which they thoroughly enjoyed.