We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

St Mary's Nursing Home

Montilio Lane, Harborough Magna, Rugby, CV23 0HF
Tel: 01788832589

Date of Inspection: 07 May 2013
Date of Publication: June 2013

We inspected the following standards as part of a routine inspection. This is what we found:

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<td>✔ Met this standard</td>
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<td>Assessing and monitoring the quality of service provision</td>
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<th>St Mary's Nursing Home</th>
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<tr>
<td>Registered Manager</td>
<td>Mrs. Ann Manklow</td>
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<tr>
<td>Overview of the service</td>
<td>St Mary's Nursing Home is registered to provide accommodation to up to 56 people who require nursing or personal care.</td>
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<td>Type of services</td>
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When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 7 May 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

During our visit we spoke with four people about their experience of living in the home. We were told, “The food is good and I have a nice bedroom. The staff are nice to me” and "I'm quite content here."

We spoke with five visitors who made positive comments about the care and support their relatives received. We were told, "This is a lovely home, it's always clean and I am made to feel welcome" and "It's very good here. Staff are friendly and helpful."

We looked at the care records for three people and found that their needs were assessed prior to admission so that plans of care and support reflected the way people liked and needed to be cared for. We found that care records were reviewed on a regular basis to make sure they accurately described the care people needed.

The members of care and nursing staff we spoke with told us that staff meetings and formal supervision sessions took place infrequently. We were informed however that information about people's needs was discussed at the daily handover at the start of each shift.

We observed that staff responded promptly to people when they asked for support and treated people with respect whilst providing care.

We looked at the way medicines were being managed to make sure people received their medication in a planned and safe way.

We found that there was a system of measuring the quality of the service provided to people so that improvements could be made, based on people's comments and suggestions.

You can see our judgements on the front page of this report.
More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

**Care and welfare of people who use services**  ✔ Met this standard

**People should get safe and appropriate care that meets their needs and supports their rights**

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**Our judgement**

The provider was meeting this standard.

People experienced care and treatment that met their needs and protected their rights. Some people received support at lunch time in a manner that was not dignified or respectful of their individual needs.

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**Reasons for our judgement**

We saw that the home had equipment and adaptations which met people’s individual needs, such as pressure relieving mattresses, hoists and bathing aids. Lounges and dining rooms had been arranged so that people using mobility aids had space to move around freely and safely. We found that tactile artwork was displayed on the walls and saw several ‘rummage’ boxes placed in the home’s lounges. We were told that these items helped calm people with dementia when they experienced distress.

The people we met and spoke with had clearly received personal care on the morning of our visit. We saw that people had had their hair styled and observed many of the women wearing jewellery and nail polish. A visitor told us, "Mum always looks well cared for."

We observed staff assisting people at lunch time on both floors of the home. We found that some people who had lunch in the ground floor dining room did not receive sufficient support to eat their meals in a manner that was dignified and respectful. We saw staff standing over people to help them to eat without speaking to them. In some cases plate guards were positioned so that people spilled food on to their clothes and a few people were not offered a drink with their meal. We discussed our observations with the registered manager who assured us she would address this as a matter of urgency with the staff team.

We found that the mealtime on the nursing floor provided a relaxed and social atmosphere for people. We saw that people who needed assistance with eating had individual help from staff who were attentive and patient. These people were supported to eat at their own pace and were settled at the table or on their chosen chair before starting their meal. Care staff engaged people in conversation whilst doing this.

We also observed the lunchtime support for four people who were too frail to join others in the dining room. It was noted that each person's meal was brought to them on a tray by a
staff member who then supported them to eat their meal. This meant people had a meal that was warm and when staff were available to assist them.

We looked at six people’s care plans and care records to see how staff had assessed and planned the care and support people needed. We saw that where possible people had been included in this process and that their routines and preferences had been recorded so that planned care was unique to them. We saw that family members had been included in the planning process where it was difficult for individuals to make this contribution.

A visitor told us, "I was asked to provide as much information as possible when X moved in. I wrote it all down and it got put in the care plan. I have noticed a real difference for the better since X has been here."

Members of the care staff team told us that care plans and risk assessments were reviewed on a regular basis to make sure they reflected people's needs. For example, we saw that care plans had been updated to meet people's short term health care needs such as the prescription of antibiotics. The provider may find it useful to note that some risk assessments had not been dated which made it difficult to establish whether they remained relevant to people's current needs.

The records we looked at showed that there was a system of monitoring people's health and well being. We saw completed food and fluid intake charts, weight records and records of people's skin type to reduce the risk of pressure ulcers. A nurse told us, "We record any marks on the skin and set up body maps to let the team know if anything looks suspicious. No one has a pressure ulcer at the moment."

We were told that the local doctor visited the home twice a week or as needed between those times. The records we looked at showed that staff had made prompt referrals to health care professionals when concerns were raised and recorded the outcome of appointments which were shared during the handover process between shifts. This meant that staff had accurate and up to date information about people's health care needs.

A visitor told us, "The staff told me Y was off his food. They got a nutritionist involved and everything is OK now."

We found that details of people's cultural and religious needs had been included in their care plans, for example the provision of 'same gender' personal care. We were told that Mass and Holy Communion services took place twice a month in the home.

We spoke with one of the two activity co-ordinators employed within the home who showed us records of some of the events which had taken place in the last month. The events included a visiting musician, planting flowers and vegetables in raised flowerbeds in the gardens, feeding the birds, arts and crafts and looking at old photographs. One person told us, "I like watching the birds on the feeder outside my bedroom."

The activity organiser for the nursing floor was not on duty on the day of our visit. We found that people were not engaged in any meaningful activity during our visit. Staff engaged with people in a kind and friendly manner, but the interactions we observed throughout the inspection focused on tasks and personal care. The provider may find it useful to note that there was no evidence that staff had sought the previous life experiences of people on the nursing floor. The nurse in charge told us that the activity organiser kept a record of people's lifestyle preferences, but was unable to find evidence that this had been done.
Management of medicines

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

We looked at the way medicines were being managed to make sure people received their medication in a planned and safe way.

We found that on both floors medicines were stored securely in locked trolleys in a locked room. We saw that there were separate and secure storage areas for controlled drugs and a controlled drugs register. We were told that only qualified nurses were permitted to administer medicines. Observation of the home’s staffing rota for the week of our visit showed that nurses were on duty at all times.

We observed some people being given their medication at lunch time. The nurses told people what they were doing and offered people a drink to receive their tablets. We saw that nurses placed tablets into tots (a small container) and did not handle tablets. This meant that medicines were handled appropriately.

The care records we looked at described the medication prescribed for people, any known allergies and the way the person preferred to receive their medication. We found that records for people with diabetes contained twice daily entries about their blood/sugar levels and information about the action to be taken should readings be too high or too low.

We looked at the medication administration records for six people and found that there were written protocols in place for people who took medication ‘as required’ for health or other reasons. The nurses we spoke with were aware of the circumstances under which such medication should be offered to people. This meant that medicines were safely administered.

We saw that medicines audits had been conducted on a monthly basis to make sure nurses were following the home’s medication policy. We looked at the most recent audit which identified two occasions of the number of tablets in stock being different to the number on the medication administration record. The provider may find it useful to note that there was no further information to describe what had been done to investigate the anomalies.
Requirements relating to workers

People should be cared for by staff who are properly qualified and able to do their job

Met this standard

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

We saw that appropriate checks were undertaken before staff began work.

We looked at the personnel files for four staff members. Each file contained evidence that satisfactory pre-employment checks such as police checks and references were obtained to make sure the staff were suitable to work with vulnerable people.

We saw that staff's responses to interview questions were held on their file. This meant that staff were selected fairly and were considered the most suitable applicant to meet the needs of people using the service.

We spoke with a member of staff that had recently been employed by the service. They told us that although they had worked briefly in care before, they were extra to the number of staff on the rota during their induction. They said that this was so they could learn about the people that lived in the home and how the management wanted them to work. They also confirmed that they had not been allowed to work without supervision until their pre-employment checks had been obtained.

Information in staff files and discussion with staff evidenced that a staff induction programme was in place. This included shadowing an experienced worker until the care worker was deemed competent.
Supporting workers

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

We spoke with a new member of staff who told us about their induction and what this had covered. They told us this had involved working alongside an experienced staff for a while, reading care records and completing training in manual handling, infection control and fire safety. This meant that new staff coming to work at the home received support and guidance to deliver basic care safely and understand the needs of people using the service.

Records showed that staff had completed various health and safety courses such as first aid, food safety, safeguarding vulnerable people, moving and handling, fire safety and infection control.

The provider may find it useful to note that staff spoken with told us that staff meetings did not take place on a regular basis. However, they told us that daily handovers took place at the start of each shift which ensured they had appropriate information to support the people living in the home. From discussions with staff and the manager it was evident there were suitable communication systems to enable staff to fulfil their role and support people safely.

The provider may find it useful to note that staff also told us that regular supervision sessions did not take place. Individual supervision is an opportunity for staff to meet with management to discuss their work and training needs enabling them to develop in their role. We discussed supervision with the manager who provided evidence that all staff in the home had received supervision approximately six months previous. She advised that they were updating the service's staff supervision policy to ensure all staff received supervision as least four monthly, or sooner if applicable to the staff member. She also confirmed that she would meet with staff on a one to one basis at any time, if a staff member requested it.

Throughout the day of our visit we observed how care staff provided support to people living in the home. We saw that staff were attentive and responsive to the needs of the people they cared for. We saw a number of staff demonstrated a person centred approach to how they supported people living in the home. They displayed patience and understanding in the manner in which they interacted with the people they cared for. One
person told us, “They are all very kind and caring.” A visiting family member said, “The staff are excellent, I have every confidence my relative receives good care.”
Assessing and monitoring the quality of service provision

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

The manager showed us some of the systems in place to monitor the quality of the service provided in the home. We saw a range of quality audit records including environmental, cleansing and health and safety checks as well as an audit of incidents and accidents. We looked at monthly records which showed the action taken in response to people who suffered falls so that the risk of further incidents could be reduced.

We were told that specialist equipment such as hoists and bathing aids were serviced on a regular basis to ensure they remained 'fit for purpose' and in good working order. The records we looked at confirmed this.

We were told that an infection control nurse had visited the home during the week before our visit. The manager commented that she had not received a report of the audit undertaken but that there were no major issues as a result of the nurse’s visit. We spoke with the infection control nurse who told us that the manager had been pro-active in requesting the audit.

We looked at records which showed that people's bedrooms were checked each month for minor repairs and redecoration. The records identified the actions taken in response to any issues arising. One person told us, "My room suits me. I have had new bedclothes."

The care staff we spoke with told us that they would raise any concerns they had about risks to the people living there or poor practice, with the manager or senior staff. We were told they were confident that if a concern was reported, the management team would act upon it.

We were told that an annual survey had been completed to gather information about people's views, or that of their relative's, of the quality of care and service provided in the home. We looked at some of the responses from the most recent survey in 2012.
Many people had commented that their bedroom facilities, the quality of care received and the food offered were 'good' or 'excellent'. One person consistently gave a 'poor' or 'adequate' response to the questions asked. The provider may find it useful to note that there was no further information recorded to describe the action taken following the person's comments.

We saw a number of thank you letters and cards displayed around the home praising staff for their care, kindness and attention to people.
About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as “government standards”.

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

<table>
<thead>
<tr>
<th>Met this standard</th>
<th>This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.</th>
</tr>
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<tr>
<td>Action needed</td>
<td>This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.</td>
</tr>
<tr>
<td>Enforcement action taken</td>
<td>If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.</td>
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How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact** – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
### Glossary of terms we use in this report

#### Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

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#### Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.