St Mary's Convent and Nursing Home (Chiswick)

St Mary's Convent and Nursing Home

Inspection Report

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Overall summary

St Mary's Convent and Nursing Home is a care home providing accommodation for up to 59 older people who require nursing, personal care and support. When we visited, 57 people were living in the home. The home had a registered manager in post. People living in the home and their relatives commented positively on her "caring nature" and told us she promoted high standards of care.

People we spoke with told us they were happy with the care and support they received. One person said "I am very happy here. We get excellent care. When I want them I call them and they come. Sometimes two or three of them. The sisters are 'just there' and I have two daughters who live nearby and visit regularly." A second person told us "I can't say enough. I would give them all a medal. Every one of them. They go that one step farther. I don't call them helpers, they are friends." A relative also told us "The carers are really caring. My [relative] is prone to fits and they ring me at home whenever she has had one, just to let me know, even though everything is alright."

We saw most people had the support they needed at lunch time and they were encouraged to make choices about what they ate and drank. However, some people who needed help with eating were not supported in a respectful and dignified way.

The care staff we spoke with demonstrated a good knowledge of people's care needs. However, the care plans we looked at did not include clear guidance for staff on the care people needed. This meant staff did not have the information they needed to care for and support people in the ways they preferred in a respectful, safe, caring and dignified way.

There was a need to make sure staff understood and followed the provider's procedure for safeguarding people using the service. Incidents that should have been reported to the local authority safeguarding adults team and the Care Quality Commission were not identified as safeguarding concerns by the home.

We saw all communal parts of the home and some people's bedrooms, with their permission. We saw the home was clean, hygienic and well maintained.

The problems we found breached health and social care regulations and the action we have asked the provider to take can be found at the back 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.

Are services safe?

People and their relatives told us there were enough staff working to make sure people did not have to wait for care and assistance. Staff also told us there were usually enough staff to support people. We saw there were enough staff to support people in their rooms and communal areas.

The home was safe and well maintained. Arrangements were in place for regular health and safety checks and the service and maintenance of equipment.

People living in the home had assessments of possible risks to their health and welfare and these were reviewed at least monthly. This meant staff were aware of the current identified risks to individuals and were able to manage these to make sure people were safe. However, two risk assessments were incomplete and the level of risk had not been assessed accurately. This meant there had been a breach of the relevant legal regulation (Regulation 9 (1) (a)) and the action we have asked the provider to take can be found at the back of this report.

Care staff we spoke with were not aware of the need to report safeguarding concerns to the local authority and the Care Quality Commission. Staff were also unaware of the provider's safeguarding and whistle blowing procedures. This meant there had been a breach of the relevant legal regulation (Regulation 11(1) (b)) and the action we have asked the provider to take can be found at the back of this report.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards. While no applications had been submitted, proper policies and procedures were in place but none had been necessary. Relevant staff have been trained to understand when an application should be made, and in how to submit one.

Are services effective?

People's health and social care needs were assessed and people were involved in making decisions about their care wherever possible. If people could not contribute to their care plan, staff worked with their relatives and other professionals to assess and provide the care they needed.

Summary of findings

However, while people's care plans included information about their health and personal care needs, there was insufficient guidance for staff on how these needs should be met. For example, where assessments identified a person was at risk of falling, staff were not given guidance on how to support them with their mobility. This meant there had been a breach of the relevant legal regulation (Regulation 20 (1) (a)) and the action we have asked the provider to take can be found at the back of this report.

Are services caring?

People living in the home told us staff were kind and caring. Relatives and visitors told us they felt people were well cared for and staff treated people with respect. However, we saw at lunchtime that people were not always treated with respect by some staff. For example, we saw some staff did not talk with people while supporting them and one member of staff was attempting to help two people with eating at the same time. This meant there had been a breach of the relevant legal regulations (Regulation 17 (2) (a); Regulation 9 (1) (a and b)) and some people's dignity was not respected by some care staff. The action we have asked the provider to take can be found at the back of this report.

People told us funeral services were usually held in the home's chapel so all residents could attend and many people chose St Mary's for spiritual reasons.

Are services responsive to people's needs?

People told us they enjoyed the activities provided. A relative told us the activities provided were "excellent."

Where people were not able to make decisions about their care, staff worked with their relatives and other professionals to make sure 'best interest decisions' were agreed.

Relatives told us they had been given a copy of the provider's complaints procedure when their relative moved into the home but they had never needed to make a formal complaint.

Are services well-led?

The home had an experienced and qualified manager. Staff told us they felt well supported by the manager and senior staff and they understood their roles and responsibilities.

The provider had systems in place to monitor standards of care provided in the home.

However, we found evidence the provider had failed to notify CQC and the local authority of serious incidents at the home. This meant the provider had not involved other agencies to make sure people in

Summary of findings

the home were not at risk of receiving unsafe or inappropriate care. This meant there had been a breach of the relevant legal regulation (Regulation 18 (2) (e)) and the action we have asked the provider to take can be found at the back of this report.

Summary of findings

What people who use the service and those that matter to them say

We spoke with 12 people who lived in the home and four relatives who were visiting when we inspected. We also spoke with nurses, care staff and managers. People living in the home who were able to express their views told us they were very happy with the care and support they received. One person told us "I set my own routine. I like to have breakfast in bed and they bring it up to me. I go downstairs later in the morning and have lunch with everyone. I'm usually tired after lunch and I come back upstairs to rest. It's fantastic [here]." Another person said "I can't think of anything wrong with the place to complain about apart from supper being at six o'clock. Apparently they can't change it on account of staff needing to get home, which I understand. It's a proper three course hot meal; not just sandwiches."

A relative told us "the carers are really caring. My [relative] is prone to fits and they ring me at home whenever she has had one, just to let me know, even though everything is alright."

Another relative told us "the doctors did not expect him to get out of bed again" She told us she had looked at many homes and only St Mary's seemed able and fully prepared to help. She had been able to discuss how her [relative's] care would be managed in advance of his admission.

St Mary's Convent and 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 was planned to check whether the provider is meeting the regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

We visited the home on 04 April 2014. We spent time talking with people living in the home, their relatives, visitors, the quality assurance and deputy managers, nurses and care staff. We observed care in two dining rooms at lunchtime and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were not able to speak with us.

We looked at all communal parts of the home and some people's bedroom, with their agreement.

We also looked at five people's care records and records relating to the management of the home.

The inspection team consisted of an Inspector and an Expert by Experience who had experience of services for older people. This inspection was part of the first test phase of the new inspection process we are introducing for adult social care services.

Before our inspection we reviewed the information we held about the home, including the outcome of the last inspection in October 2013.

On the day we visited we spoke with 12 people living in the home, four relatives and visitors, four care staff and three nurses. We also spoke with the home's registered manager, deputy manager and quality assurance manager. We also spoke with the local authority's safeguarding adults team.

Are services safe?

Our findings

We looked at care records for five people living in the home and saw risk assessments were completed when required. We saw assessments covered falls; moving and handling; pressure care and nutrition. In three of the five care plans we looked at, where risks were identified, staff were given clear guidance about how these should be managed. However, in two cases the risk assessments were incomplete or the wrong conclusion had been reached following the assessment. For example, one person's pressure care assessment had been calculated incorrectly and the wrong level of risk was recorded. A second person's moving and handling risk assessment had been started but not completed, with no guidance for staff as to how the person should be supported. This meant some people were at risk of not receiving the care and support they needed. This meant there had been a breach of the relevant legal regulation (Regulation 9 (1) (a)) and the action we have asked the provider to take can be found at the back of this report.

We saw most risk assessments were reviewed by staff each month. Staff told us if there were changes in a person's care needs they would report to the nurse in charge and a risk assessment would be reviewed or completed. One care assistant told us "if I noticed somebody was losing weight I'd tell the nurse straight away."

Staff told us they had received safeguarding adults training as part of their induction and this was confirmed by the training records we saw. However, we asked four care staff what they would do if they felt a person living in the home was being abused. All were unsure about what to do apart from telling the nurse in charge. None of the staff understood safeguarding concerns should be reported to the local authority and CQC. None of the staff we spoke with mentioned the home's safeguarding or whistleblowing procedures. This meant, although staff had the training they needed, they had not fully understood how to make sure people living in the home were cared for safely. This meant there had been a breach of the relevant legal regulation (Regulation 11(1) (b)) and the action we have asked the provider to take can be found at the back of this report.

People told us they felt well cared for and safe in the home. Their comments included "the care is very good, the sisters and staff are lovely" and "I feel well cared for, it wasn't safe for me to stay at home." A relative also told us "I am relieved he is here where he is safe; whatever happens they know how to deal with it."

People and their relatives also told us staff usually responded to requests for care and support promptly. One person said "I am very happy here. We get excellent care. When I want them I call them and they come. Sometimes two or three of them."

During the inspection we saw there were enough staff to support people in communal areas and their bedrooms. We did not see people having to wait for staff if they needed help. Nurses and care staff we spoke with told us there were enough staff to meet people's needs safely. One person said "I can rely on my colleagues, there's always someone to help." Another person said "there are always enough staff. It gets busy at certain times but we manage."

During the inspection we saw all communal parts of the home and some people's bedrooms. We found the premises and equipment were safe and well maintained. We saw servicing and maintenance records were up to date and action was taken to address issues identified. For example, one issue was identified in the legionella safety check of the home's water system in January 2013 and this was addressed immediately. A fire safety risk assessment was completed by an independent fire safety consultant In November 2013 and no concerns were identified. We saw records of weekly fire alarm tests and monthly fire drills were kept. We saw fire safety records, gas and electrical safety certificates, legionella checks and service records for equipment used in the home were up to date.

Are services effective?

(for example, treatment is effective)

Our findings

The care plans we looked at included a pre-admission assessment of the person's health and social care needs, life history, hobbies and interests. The assessments were detailed but we did not see the information was used to develop clear guidance for care staff on how each person should be cared for and supported. For example, care needs and risk assessments identified one person had a history of falls but there was no guidance for care staff about how the person should be supported with mobility. Other assessments showed people needed support with their personal care but there was no guidance for care staff as to how this should be provided. Care staff we spoke with said they looked at people's care plans but relied on colleagues who knew people well to tell them what support each person needed. This meant there had been a breach of the relevant legal regulation (Regulation 20 (1) (a)) and the action we have asked the provider to take can be found at the back of this report. We discussed this with the deputy manager and quality assurance manager during the inspection. They told us the management team had identified the need to review the home's care planning systems to include clearer guidance as to how people's care needs would be met in the home and this work was continuing.

People told us they were involved in planning and reviewing the care and support they received. This was confirmed by the care records we looked at for five people. One person said "but of course they do [consult me about planning my care]. They let me do what I want. They are so kind. I am so lucky. Anything I need, they do it and they do it graciously." A relative told us "they always involved my [relative] and the family in making decisions about care. The initial assessment was very detailed." Another relative told us she had looked at many homes and only St Mary's seemed able and fully prepared to help. She had been able to discuss how her relative's care would be managed in advance of his admission.

The staff completed daily care notes for each person and we saw these mainly covered their health and personal care needs. While there was evidence people were involved in activities, the records did not show how engaged people were with the activity or their enjoyment of it.

People's care plans included information about visits by the GP or other clinicians and hospital or clinic appointments. The nursing staff we spoke with were also able to tell us about people's health care needs and how these were met in the home. People told us they could talk to staff about their care and most said they had access to health care services when necessary. One person said "they took me to the hospital. Someone came with me and they examined and X-rayed it and found a very small fracture. So that was just as well."

People's care plans also included an assessment of their nutrition and hydration needs. We saw nutrition assessments were completed and regularly reviewed. People living in the home and staff told us an emphasis was put on eating all meals apart from breakfast together. The home was able to provide a suitable environment for everyone by having three different dining areas for people who eat more slowly or have different social interaction needs. This allowed for a service in the main dining room which evoked the feel of eating around the table at home and at which guests can join their relatives. People in this dining area told us they liked this arrangement and the idea of eating a meal other than breakfast alone in their room seemed strange to them when we suggested it.

Are services caring?

Our findings

Our SOFI observation at lunchtime took place in a dining room where people needed assistance to eat and drink and we saw some people did not have a good experience. For example, one care assistant sat between two people and attempted to feed them both at the same time. There was little interaction with either person and at one point the carer left the table without explanation. We saw another care assistant put a spoonful of food that was too hot into a person's mouth; the person was startled and reacted by pulling back from the spoon. The care assistant did not speak to the person to apologise and just sat for several minutes waiting for the food to cool down. We saw a third care assistant over-filled the spoon when feeding another person and used the spoon to scrape food from the person's face and mouth. We discussed this poor practice with the deputy manager and quality assurance manager during the inspection. They told us care staff had completed training in treating people with respect at mealtimes but said they would discuss our observations with the manager. This meant there had been a breach of the relevant legal regulations (Regulation 17 (2) (a); Regulation 9 (1) (a and b)) and some people's dignity was not respected by some care staff. The action we have asked the provider to take can be found at the back of this report.

During our inspection we saw staff treated people with patience and understanding and spoke with them in a respectful way. We saw staff always knocked on people's doors before entering their rooms. When a member of staff wanted to introduce us to someone who was in their room, they entered the room alone to obtain the person's consent before we were shown in, or not. We saw people were able to move around the home freely and there were no locked doors. The front door and outer gates were locked and the grounds were free of hazards, even though building work was going on.

People told us staff were kind and caring. They also said they were offered choices and staff knew about their preferences and daily routines. One person said "I am very happy here. We get excellent care. When I want them I call them and they come. Sometimes two or three of them. The sisters are 'just there' and I have two daughters who live nearby and visit regularly." A second person said "I can't say enough. I would give them all a medal. Every one of them. They go that one step further. I don't call them helpers, they are friends." A third person told us she enjoyed gardening and staff had set aside an area of the garden for her to care for which they had named after her.

A visitor told us how she felt the staff worked with her relative to manage his transfers by hoist. She said "my [relative] finds the hoist terrifying, however they talk to him and reassure him. They know that he feels much safer if he is holding on to something and they make sure he is. You can't just tell him to hold on, you have to put his hand there and they do that." A second relative said "it's a very special place. All of the staff care so much."

Other people were offered choices, allowed time to finish their meals at their own pace and encouraged and supported to eat and drink, if necessary.

There was an on-site chapel where Mass was celebrated several times a week. In addition the sisters performed various offices which people could attend. There was a large area in the chapel to accommodate wheelchairs. We were told that attendance at chapel was not compulsory and this was confirmed by two people independently. We were also told funeral services were usually held in the chapel so people could attend and many people chose St Mary's for spiritual reasons. People told us a death at St Mary's was an important event in their spiritual life, and residents could be assured that their own death would be properly respected and acknowledged.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People told us they were able to make decisions for themselves and staff supported them to maintain their independence. One person said "I set my own routine. I like to have breakfast in bed and they bring it up to me. I go downstairs later in the morning and have lunch with everyone. I'm usually tired after lunch and I come back upstairs to rest." Another person told us "I'm not able to do everything I used to but I do what I can for myself, the staff are very patient."

People told us they enjoyed the activities that were arranged. One person said "I enjoy going to the park in the nice weather." We saw a timetable of a full list of activities and observed some of these in action. The day we visited it was Coffee Morning followed by Games and then a film in the afternoon. They were all well attended and not just the same group at each. The coffee morning was popular and it allowed people to get together regularly in a particular place at a particular time. We were told that the weekly sherry party was the most popular activity and thirty or more people sometimes attended that. The activities coordinator told us they made regular trips outside the home using up to three mini busses depending on the popularity of the trip. Pub lunches were a big draw as were trips down to the river during fine weather. We were told that people using wheelchairs were also supported to take part in these trips.

During the inspection we saw staff offered people choices about activities and what to eat. Staff usually waited to give people the opportunity to make a choice. For example, at lunchtime in the main dining room, staff reminded people of the available choices and allowed time for them to make a choice. We saw one person asked for a meal and then changed her mind and this decision was respected by staff.

Relatives we spoke with told us staff kept them informed about people's care and welfare and any significant events or changes. We saw people's care plans included contact details of their next of kin, including whether or not they should be contacted during the night. The care records we looked at showed some people were involved in planning the care and support they received and they signed their care plan to record this involvement.

People who were not able to make specific decisions and needed an assessment under the Mental Capacity Act 2005 had received one. Where a relative had a power of attorney this was clearly recorded so staff knew who to contact about decisions relating to the person's care. When people were unable to make decisions about their care, this was discussed with relatives and other relevant people and a 'best interest' decision was agreed and recorded. Staff we spoke with told us they had completed training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and this was confirmed by the training records we looked at.

People living in the home and their relatives told us they had never needed to make a formal complaint. One person told us "[the nominated individual] is so open. I can talk to her about anything. If I have a problem it's dealt with there and then." Relatives told us they had been given a copy of the provider's complaints procedure when their relative moved to the home. Managers we spoke with told us most complaints were resolved by nursing and care staff and did not proceed to the formal procedures. We looked at the record of complaints received and saw formal complaints were clearly recorded, with a record of actions taken and the outcome. This meant people were supported to express any concerns or complaints about the service they received.

Are services well-led?

Our findings

When we looked at information we held about the home before this inspection we saw CQC had received no safeguarding alerts from the home in the past 12 months. During this inspection we identified two safeguarding incidents that were not reported to the local authority and CQC. We discussed these incidents with the home's Quality Assurance Manager and the local authority safeguarding team. All agreed the incidents identified should have been treated as safeguarding concerns. Failure to report safeguarding concerns meant that people living in the home may have been at risk of unsafe or inappropriate care. This meant there had been a breach of the relevant legal regulation (Regulation 18 (2) (e)) and the action we have asked the provider to take can be found at the back of this report.

The home had a manager in post who was registered with the Care Quality Commission (CQC). People living in the home, their relatives and staff told us they felt the provider and manager provided leadership and promoted good standards of care. One person told us "[the manager] is always available if I need to speak with her about anything." Another relative said "the manager is very good, she has high standards and that is passed on to the staff."

Staff told us they felt well supported by the manager and senior staff and they understood their roles and responsibilities. They told us they were able to access the training they needed to do their jobs. One member of staff said "yes, I can ask any of the senior staff or the manager for advice, people are always happy to help." Another staff member said "I've learnt a lot working here, it's a very good home."

During this inspection we saw there were enough staff to support people and meet their care needs. We saw requests for help or support were usually responded to promptly and people did not have to wait for help. A relative said "there are always enough staff and the sisters as well of course." A second relative said "I have to go to work and I know there are enough staff to make sure my [relative] is safe and happy."

The Quality Assurance Manager showed us the results of satisfaction surveys completed by people living in the home in July 2013 and their relatives in September 2013. People were asked for their views on the care they received, the activities and food provided and any improvements they could recommend. Most of the comments included in both surveys were very positive and the majority of people and their relatives were happy with the care they received. We saw where issues were identified, the provider took action to address these.

We saw the provider had systems in place to monitor the service provided in the home. For example, an audit of baths, showers, toilets and wash hand basins had been carried out in February 2014 and arrangements were in place to service assisted baths and hoists. Hot water temperatures were tested and recorded each month and the provider's electrician carried out monthly checks of electrical equipment and lighting. Where audits identified issues, the records we saw showed these were addressed.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users. People who use services were not protected against the risks of receiving care and treatment that is inappropriate or unsafe as risk assessments were not completed fully or accurately. Regulation 9 (1) (a).

Regulated activity	Regulation
	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding service users from abuse. People who use services were not safeguarded against the risk of abuse because the provider did not respond appropriately to any allegation of abuse. Regulation 11 (1) (b).

Regulated activity	Regulation
	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users. Some people using the service were not treated with consideration and respect at all times. Regulation 17 (2) (a).

Regulated activity	Regulation
	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider did not notify the Care Quality Commission without delay of any abuse or allegation of abuse in relation to a service user. Regulation 18 (2) (e).

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records. The provider did not keep an accurate record in relation to the care and treatment of each service user. Regulation 20 (1) (a)