Poor Servants Of The Mother Of God

Maryville Care 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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This comprehensive inspection took place on 23 and 24 October 2018 and was unannounced. The last comprehensive inspection took place in March 2016. The service was rated requires improvement in the key question, 'is the service caring?' but there were no breaches of the regulations. At this inspection we found the provider had improved the rating for this key question but has been rated requires improvement overall and in the key questions of 'is the service safe?' and 'is the service well-led?'

Maryville is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection 37 people were using the service.

There was a 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 and associated Regulations about how the service is run.

During the inspection we found the door to the sluice room, where cleaning materials were stored, was open and the main door to the kitchen and laundry room was unlocked. This meant people were not protected from the potential hazards and risks in these rooms.

The provider had a number of systems in place to monitor, manage and improve the care and support provided to people. This included a complaints system and service audits. However, these were not always effective in identifying concerns such as the ones identified during the inspection.

The provider had policies and procedures in place to protect people from abuse. Staff we spoke with had received training and knew how to respond to safeguarding concerns. People had risk assessments and risk management plans in place to minimise risks.

Safe recruitment procedures were followed to ensure staff were suitable to work with people and we saw there were enough staff to meet the needs of people using the service.

Medicines were managed safely and staff had appropriate training and competency assessments to manage medicines safely.

Staff had up to date training, supervision and annual appraisals to develop the necessary skills to support people using the service.

Staff had completed training in infection control and food hygiene so they could reduce infections and cross contamination.

People's dietary and health needs had been assessed and recorded so any dietary or nutritional needs could be met. People were supported to maintain healthier lives and access healthcare services appropriately.

The provider generally worked within the principles of the Mental Capacity Act (2005). People were supported to have choice and control over their day to day decisions and staff were responsive to individual needs and preferences.

Before coming to the service, the provider undertook an assessment to determine if the service could meet the person's needs. Care plans were personalised and kept up to date. Some people's end of life care wishes were recorded. In other cases, no information was available about end of life care or about whether people should be resuscitated in an emergency and if they stop breathing. We have made a recommendation about this.

There was a complaints procedure in place and the provider responded to complaints as per their procedure.

People using the service and staff told us the registered manager was available and listened to them.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance. You can see what action we told the provider to take at the back of the full version of the report.

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

The service was not always safe.

The risk of harm to people was not always minimised as the sluice room door was open and the kitchen door unlocked.

The provider had safeguarding policies and procedures and staff knew how to respond to safeguarding concerns.

There were a sufficient number of staff employed to care for people and safe recruitment procedures were followed to make sure they were suitable to work with people using the service.

The provider had systems in place for the safe management of medicines.

The provider had an infection control policy and staff had access to personal protective equipment and infection control training.

Is the service effective?

Good

The service was effective.

The principles of the Mental Capacity Act (2005) were generally followed.

People's care needs were assessed and their preferences recorded about how they wished to receive their care.

Staff were supported to develop professionally through training, supervision and annual appraisals.

People were supported with their dietary requirements and to meet their healthcare needs.

Is the service caring?

Good

The service was caring.

People using the service were happy with the care they received and said care workers treated them kindly and with respect.

People were consulted about their care and the support they received.

During the inspection we saw that staff respected people's privacy, dignity and independence.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care. Support plans included people's preferences and guidance on how they would like their care delivered to meet their identified needs. Reviews were held at least annually.

The support plans recorded information around people's wishes, views and thoughts about end of life care.

The service had a complaints procedure and people knew how to make a complaint if they wished to.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had systems in place to monitor the quality of the care provided and make improvements, but the systems were not always effective as they did not identify concerns raised during the inspection.

The provider promoted feedback from all stakeholders and worked with other organisations to help develop their practice.

People using the service and staff felt managers were accessible and said they listened to any concerns.

Maryville Care 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 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 on 23 and 24 October 2018 and was unannounced.

The inspection team consisted of 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.

Prior to the inspection we looked at the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's safeguarding team and commissioning team and received their feedback about the service.

During the inspection we spoke with five people who used the service, three relatives, the registered manager, the deputy manager, two team leaders, five care workers, one house keeping staff, two catering staff and three health professionals. We viewed the care records of seven people using the service, the employment files for five care workers which included recruitment records, supervision and appraisals and we looked at training records for all staff members. We also viewed the service's checks and audits to monitor the quality of the service provided to people. After the inspection two more healthcare professionals emailed us to give feedback about the service.

Requires Improvement

Is the service safe?

Our findings

During the inspection we saw a sluice room door on the ground floor, that was open when it should have been locked. Disinfectant was stored in this room and was accessible to any person entering the room, including people using the service. We also saw the main door to access the kitchen and laundry room were closed but not locked. Both doors had 'Keep closed' signs on them and staff told us they were normally closed. During the inspection, immediate action was taken to place additional notices on the doors and managers said they reminded staff to close and secure doors at all time.

People using the service told us they felt safe. Comments included, "I am completely safe here. I never worry", "I do feel safe here. We're very lucky to have the grounds" and "I feel safe here. I can lock my door."

The provider had systems in place to help safeguard people from abuse including safeguarding polices and procedures. After the inspection, the provider sent us the current Frances Taylor Foundation safeguarding policy, dated February 2018 and told us this was used as part of staff training around safeguarding. The provider notified the Care Quality Commission (CQC) and the local authority of any safeguarding concerns involving people using the service. Staff we spoke with had attended safeguarding adults training, were able to identify the types of abuse and knew how to respond.

The provider had assessed the risks to people's safety and well-being. These assessments included nutritional risks, risk of pressure sores and moving and handling. Risk management plans provided guidance for staff about how to minimise the risks of harm to help keep people safe. Staff reviewed the risk assessments monthly or as needed.

The provider recorded incidents and accidents. The records described the incident, the recommendation to prevent reoccurrence and the action taken and was signed off by the registered manager. The provider also completed a monthly analysis and audit of incidents and accidents including the number of falls, who it impacted on and the action taken. This was discussed as part of the management meeting. This meant the provider could see patterns and take preventative action. There was a lesson learnt section recorded on the incident and accident form, but it was not always clear how improvements were made to the service as a result of the audit. We discussed this with the registered manager who revised their incidents analysis forms so they had a clear written overview of incidents, patterns and what steps they would implement for service improvement.

The provider had checks in place to ensure the environment was safe. They carried out regular health and safety checks on equipment and communal areas. Each person had a personal emergency evacuation plan (PEEP). Other checks in place to keep people safe in the event of a fire included communal area fire risk assessments and fire evacuation tests. The last London Fire Brigade fire safety inspection was in September 2018. An action plan had been completed to address the concerns but there were no significant concerns.

We looked at five staff files and saw the provider had systems in place to ensure new care workers were suitable to work with people using the service. The files contained checks and records including

applications, interview records, two references, identification documents with proof of permission to work in the UK and Disclosure and Barring Service criminal record checks. Nurses also had proof of registration with their professional body. New staff undertook an induction which consisted of a range of training and shadowing to develop their skills as care workers.

The registered manager told us that most people in the home were over 90 years old and as they became older their needs had increased. Most people thought there were a sufficient number of staff deployed with the right skills to meet people's needs, but some staff and one person who used the service told us they thought more staff were required. Comments included, "When I press the call button I have to wait. It's stressful for them. There's not enough staff and they don't have enough time. I'm told there is enough staff but it's too fast", "I think there is enough staff but it depends on the day if they're dealing with someone else", "We're not ever short of staff on the floor but we do struggle a bit sometimes", "Now residents are growing older and needs are greater, so we need more staff. There are more appointments which take away staff" and "On the floor we are fully staffed. People are deteriorating so their needs are increasing but we are managing it. It depends if someone is ill for example."

To address people's need increasing, the registered manager told us staffing levels were increased in April 2018 to meet service user needs. Two floors had team leaders and one floor had a nurse leading the shift. There was also a nurse who 'floated' between floors. A healthcare professional said, "There are qualified nurses and it is really well staffed. I always seem to have someone to speak to."

The provider had policies and procedures for the management of people's medicines, including PRN (to be given as required) medicines. We looked at medicines records for ten people. Each person had a pre-admission assessment, a service user profile, medicines allergies and a summary of their needs and medicines for hospital admission. Except for one person, people had appropriate PRN protocols in place. Staff who administered medicines had training and annual competency testing so they understood how to safely administer medicines. We identified minor discrepancies in record keeping but these were addressed during the inspection. Managers told us that the monthly medicines audit monitored PRN medicines and immediate action is taken to rectify any discrepancies. A medicines audit was due the week of the inspection. Staff also kept a record of storage temperatures of medicines to ensure these were stored safely.

The provider had an infection control policy in place to help protect people from the risk of infection and staff had attended training on infection control and used personal protective equipment such as gloves and aprons as required.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The provider understood the principles of the MCA but was not always consistent in recording information relating to this in people's records. For some people who used the service, it was not clear if a mental capacity assessment had been undertaken, where there were indications they might not have capacity to make a specific decision. Where relatives had signed on behalf of people using the service, there was not always evidence that confirmed they had a legal right to do so. We discuss these concerns with the registered manager and they told us they would make the necessary improvements.

However, we also saw evidence of mental capacity assessments and bests interests decisions made appropriately for people who lacked the mental capacity to consent to their care, and where people had the mental capacity to make decisions about their care, they had signed decision specific documents, for example for the use of bedrails. We observed staff offering people choices and asking how they would like to receive support. Staff told us, "Make sure you give them the choice. I always ask, even if they have dementia ask them the choice" and "You have to give them choices of what they like to do. Just because they have [illness], you still have to give them choices." The provider had also appropriately applied for DoLS authorisations for people who might have been deprived of their liberty as required.

People's needs were assessed prior to moving to the home. People told us they had been involved in their assessment and it included their medical and mental health histories, personal care needs assessments for various tasks and background history. People using the service had been placed by local authorities which also provided their assessments as part of the provider's assessment process to ensure the service could meet the needs of the people being referred to them. A social care professional said, "Maryville had prepared well for [person's] admission. The care home staff seemed to have the expertise to support and manage clients with mental health problems, approach and techniques used to relax her with understanding, respect acceptance and dignity. They employed a strength based approach in their admission assessment and support."

Staff had completed training that the provider considered mandatory. This included safeguarding adults, infection control and the Mental Capacity Act (2005). This helped to provide staff with the skills and knowledge required to deliver effective care. The provider's training data base indicated staff were up to

date with training considered mandatory by the provider and there was a record of when training was next due. Staff we spoke with were positive about both their induction and ongoing mandatory training. New staff members' training reflected the Care Certificate, which is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. Staff also undertook training that was specific to the people they were supporting such as dementia training and end of life care training had begun. The deputy manager was a dementia champion which meant they were able to lead in good practice when supporting people living with the experience of dementia. A health care professional observed, "They have appropriate skills. They seem to be moving and handling correctly. They wait to be shown how to use equipment and then pass the information on to their team."

Staff were supported to develop professionally through supervisions, appraisals, team meetings and daily handovers. Staff worked well together and told us, "Our floor is a very good team and we support each other" and "I do always say what I need to at monthly meetings. We will discuss and sort things out and try to work as a team."

People generally liked the food and told us, "You can always ask for something special [regarding food] if you feel like it. It's not wonderful but it's okay", "The food is very good. The dining room has little things and I can make a cup of coffee or have biscuits when I want" and "I'm a vegetarian. I have a sperate menu and I ask for what I want." One person said they had a specific dietary need and told us, "I don't want them to make something special, but staff know what I can't take." Care plans recorded people's dietary needs and food preferences so people could be supported to eat and drink enough to maintain a balanced diet. Snacks and drinks were available throughout the day.

People's healthcare needs were recorded in their care plans with relevant guidance. We saw their health needs were being met through access to healthcare professionals. There was evidence that people were supported to various medical appointments such as physiotherapy and the memory clinic. Weight and blood pressure was recorded when required. People confirmed they were supported with their health needs and told us, "If I need medical help, I tell staff and they do what needs to be done", "They come on time with tablets" and "Immediately something happens, and they send me to the hospital." Comments from health care professionals included, "Good atmosphere, very caring, very keen to learn. Good notes. They make appropriate referrals and ask advice appropriately. They absolutely will follow through. They are really proactive and will chase up anything that needs chased. There is clear communication." A Clinical Commissioning Group (CCG) manager told us after an "…audit in the home [we] found it overall quite responsive and caring."

People using the service had en-suite rooms which were decorated with personal items. People who needed specialist beds or other equipment in their rooms were provided with these. The service was across three floors which all had their own communal facilities. Information such as activities was displayed on each floor.

Good

Is the service caring?

Our findings

During the inspection, we observed staff offered support to people in a kind and a caring manner and responded to people's requests in a timely way. People using the service were happy with the care and support they received and told us, "They are so kind", "Very nice and friendly. Whatever I need doing, they do it willingly" and "On the whole it is a good place and we have mass every day."

Relatives were welcomed to the service and said, "Staff are wonderful. They look after [person] so well. They respect dignity and privacy", "They talk to them a lot. [Person] has a special wheelchair. [Person] goes to chapel downstairs every Sunday which is wonderful. They are happy in the chapel", "The cooperation is good. It's never no. They arrange it immediately" and "Staff are very quick to make adjustments like changing the bed to an air mattress. Their idea and very positive."

People we spoke with indicated they were involved in planning their care and able to express their views. Comments included, "Yes they did a care plan. They asked what I wanted", "Whenever they do a care plan, they bring me the sheets, I read them and if I agree I sign them" and "Yes they usually bring my care plan, and if I disagree, I tell the one who brings it." We saw that when people could not sign their own care plans, it was recorded that the care plan had been explained to them and they had been involved with it.

Staff offered people choices and promoted independence. They told us, "I can get up when I want" and "I tell them if I am having a shower, so staff are around." Staff comments included, "We have the care plan and I'm always observing. When we go in the morning we ask if they are ready to get up, show them the clothes, do you want a shower, what do you want to do for breakfast."

One staff member told us, "It is very diverse here. Once a month they have a cultural day where they share culture, food, music and show pictures." Care plans had information about people's preferences and included any cultural or religious needs. The provider employed staff who spoke several languages. They also had information about people's communication needs including language and aides they required such as hearing aids, so staff knew how to provide personalised support.

People told us staff were respectful. They said, "Staff do knock on the door. They're very nice", "Staff always knock on the door" and "Staff are respectful when helping me to wash." Staff said, "Try to respect their privacy. Communication is very important. Talk through what you are doing and if the person can participate help them to" and "I say good morning and I give them a choice. I ask what they would like. During personal care, always communicate what you are doing."

Good

Is the service responsive?

Our findings

People told us they were involved in planning their care and that their needs were being met. Care plans were personalised to include individual needs and preferences and provided guidelines for how people wanted their care to be delivered. Care plans contained information about friends, family, religion, marital history and community involvement to enable staff to support them in a person-centred manner. The care plans were developed using information from people using the service and other professionals involved in their care. In addition, staff also completed daily logs and had a shift handover. This meant staff were kept up to date on each shift and contributed to people receiving care and support that reflected their care plan. We also saw care plans were reviewed regularly to reflect changing needs.

People told us they enjoyed the activities on offer. A number of people using the service were from religious communities and said the availability of a priest and a daily mass were important to them. Other activities included coffee mornings, art classes, pets as therapy, therapy dogs, bingo and weekly aromatherapy sessions. On the provider's satisfaction survey, 17 people and relatives responded and 13 said that there was wide range of activities in the home. Where three people had said they could not access the home's activities, a member of staff had been identified to support them in this area. A relative said, "I think it is full of very kind people. The facilities seem very good. Fulfils spiritual needs. They have enough activities and good access to the GP and the dentist and if [person] needs to go out, someone takes her there. I am impressed of readiness of staff to take [person] out to go to the shop or a coffee."

The provider had a complaints procedure dated 2014 and people we spoke with knew how to make a complaint. Complaint forms were located in the reception area but the deputy manager told us most people preferred to raise any concerns verbally. We saw each complaint was investigated and responded to in line with the procedure and actions recorded.

Comments from people using the service included, "If I have a complaint, I just tell [the registered manager]" and "There's a notice how to make complaints, but I would go to the nurse."

People being cared for at the end of their life were given the care they required. We saw a number of cards from relatives thanking the home for their care at this time. Care plans contained people's end of life wishes where people were happy to discuss them but for people who did not want to have that conversation, it was not clear from the care plans what efforts had been made to try and discuss it. This was also the case for the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms which meant not all people had completed DNACPR forms. We talked with the registered manager about ensuring there was a clear record to show what attempts had been made to ascertain people's end of life wishes. After the inspection, the registered manager wrote to us, 'All residents have an end of life care plan. However, discussion around end of life care is a very sensitive area of care that needs to be discussed at a comfortable time with resident or their relative as this may sometimes cause distress.'

We recommend that the provider seek and implement national guidance on meeting the end of life care needs of people in social care.

Requires Improvement

Is the service well-led?

Our findings

During the inspection we found the provider had data management systems to monitor service delivery, but these did not pick up missing information identified in the inspection such as a clear analysis and how the information from safeguarding alerts, complaints and incidents were used to improve service delivery. We also found that not all PRN protocols were in place, inconsistent implementation of the Mental Capacity Act (2005) and a lack of clear records to demonstrate that end of life care wishes and wishes of people or decisions about DNACPR had been discussed with all people using the service or their representatives and recorded.

On the day of the inspection, the provider had also failed to identify the risks associated with unlocked sluice rooms, the laundry and the kitchen and taken action to protect people against such risks. People were able to access cleaning products which could have placed them at risk of harm.

This above are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discuss these concerns with the registered manager and deputy manager and they told us they would make the necessary improvements.

Audits included medicines and fire equipment and cleaning checklists. The internal manager's audit monitored service user files, risk assessments, communication and policies and procedures. There was an action plan with a date for actions to be completed by. Monthly reports were sent to the organisation's head office. The audits and checks provided the registered manager with an overview of the service so they could respond to issues, minimise risks and improve service delivery.

The manager had a record of when supervisions and training were due to ensure care workers were provided with the support and training they needed to provide effective care.

People using the service had the opportunity to give feedback and share their views about the service they received to the provider through a number of ways including surveys and residents' meetings. The last survey from May 2018 collated the answers and produced an action plan to improve service delivery. In addition to supervisions and appraisals, staff also had the opportunity to participate in team meetings and share information so they were involved in the way the service was provided.

People using the service found the registered manager approachable and told us, "[Registered manager] will talk to you. She calls in occasionally. She sits down and has a chat", "When I have worried I have spoken to [the registered manger] and she said don't worry and sorted it out" and "I find I am able to speak to them [managers] all quite easily." A relative commented, "[Registered manager] is available any time. If I need something I send her a text and within half an hour I get a response." Staff said, "[Registered manager] keeps us informed. If there is something she will put it on the notice board. She will listen, but it hasn't happened to me to report something" and "[The registered manger] is very strict. She is always around the

floor and makes sure the clients are okay. She always asks them if everything is okay."

The registered manager notified the Care Quality Commission of specific incidents as required. They kept up to date with good practice through contact and newsletters from the local authority and CQC.

The provider worked with other professionals such as social workers and GPs. A clinical commissioning group (CCG) professional said, "I can confirm that Maryville Care home are committed to implementing our new service specification within their care home and are participating in training programmes currently being offered to homes across Hounslow. The home took part in the diabetes management programme on Friday, last week."

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure systems were operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users or to monitor and improve the quality and safety of the service. Regulation 17(1) (2)(a)(b)