St Mary's Convent and Nursing Home (Chiswick)

St Mary's Convent and Nursing Home

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?	Outstanding
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
St Mary's Convent and Nursing Home is a care home providing accommodation for up to 60 people who require personal care and support. At the time of the inspection there were 57 people using the service. The service was divided into four units for people who required nursing care and residential care.

People's experience of using this service and what we found
People received exceptional person-centred care and were supported to have choice and control. Care plans were personalised and recorded people's preferences, so staff knew how to respond to people's needs in an effective but sensitive way. There were various activities on offer and people could choose to engage in activities that were meaningful to them. People were supported with their interests and links with the community were maintained. Families were welcomed to the home. There was a complaints procedure in place and the provider responded to complaints appropriately.

The provider had systems in place to safeguard people from the risk of abuse and staff knew how to respond to possible safeguarding concerns. There were also systems in place to identify and manage risks. Safe recruitment procedures were in place and there were enough staff to meet people's needs. Medicines were managed and administered safely. Staff followed appropriate infection control practices to prevent cross infection.

Supervisions, appraisals and competency testing provided staff with the support they required to undertake their jobs effectively and safely. People's needs were regularly assessed to ensure these could be met. People were supported to maintain healthy lives and access healthcare services appropriately. People were also supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People and their relatives consistently told us people were cared for by kind and supportive staff who knew the needs of the people they cared for well. The home was inclusive, respectful and staff went that extra bit further to ensure people were able to live in a way that suited their preferences and needs. People were involved in making decisions about their day to day care and their opinions were listened to and valued. Independence was promoted.

The provider had systems in place to monitor, manage and improve service delivery and to improve the care and support provided to people. People using the service and staff reported the registered manager was approachable and promoted an open work environment. All stakeholders said the home was well led. Clear leadership contributed to people and staff being positive about the management of the home and feeling valued and respected.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection
The last rating for this service was good (published 6 June 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 was safe. Details are in our safe findings below.	**Good**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was exceptionally responsive. Details are in our responsive findings below	**Outstanding** ☆
Is the service well-led? The service was well-led. Details are in our well-Led findings below.	**Good**

St Mary's Convent and Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was conducted by one inspector 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.

Service and service type
St Mary's Convent and Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and seven relatives about their experience of the care provided. We spoke with ten members of staff including the registered manager, managing director, clinical lead, nurses, care staff and kitchen staff. We also spoke with a social care professional and a health professional.

We reviewed a range of records. This included people's care records and medicines records. We looked at staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.
After the inspection
We continued to seek clarification from the provider to validate evidence found. Six relatives emailed us feedback about their experience of the service. A healthcare professional emailed us a recent report they had undertaken at the home.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question remained the same. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
• People were protected from abuse and told us they felt safe. One person commented, "Totally [safe]. I know I have my bell if I need anything. In the summer I even leave my windows open at night." A relative said, "I know [person] loves it. They feel safe. [Person] has never said anything negative."
• The provider had up to date policies and procedures for safeguarding and whistleblowing. Staff had appropriate training and knew how to raise any safeguarding concerns. There was a clear safeguarding stage and activity flow chart with responsibilities and timescales, so staff knew how to report any concerns.
• The registered manager had raised safeguarding concerns appropriately with the local authority and CQC and kept a log of safeguarding incidents with lessons learned. Where they were responsible for the investigation of the safeguarding alerts, they had attached relevant information such as witness statements and emails and appropriately recorded their investigations. There was a record of outcomes and the lessons learned to try to prevent the situation repeating itself. Where appropriate staff were written to and people informed of any actions affecting them.

Assessing risk, safety monitoring and management
• The provider had systems and processes in place to help keep people safe including risk assessments and risk management plans. These were updated each month or when required and appropriate referrals were made, for example to the dietician, continence nurse and Speech and Language Team (SALT). However, some risk assessments took time to locate on the system. The senior management team said they accepted the need to standardise how information was recorded on the system and planned to arrange peer reviews of care plans so everything was standardised.
• The clinical lead had begun undertaking audits of all risk assessments for each person and collating them on a single document that looked at risks, consequences, risk levels, control measures and residual risk levels for each person. This was in addition to individual risk assessments and provided an overview of each person's potential risk areas and the level of risk with control measures to manage the identified risks.
• Personal emergency evacuation plans (PEEPs) provided clear guidelines for how each person should be evacuated and what assistance was required to ensure people could evacuate safely in an emergency.
• The provider had checks with action plans to help ensure the environment was safe and well maintained. These included environmental risk assessments and equipment checks. Maintenance and cleaning checks were up to date.
• The provider had a business continuity plan that included Brexit preparations.

Staffing and recruitment
• Staff records we viewed showed safe recruitment procedures were in place and implemented to help ensure only suitable staff were employed to care for people using the service. After being recruited, staff

undertook an induction and training, so they had the required knowledge to care for people.
• The provider had a full staff team and covered staff absences with bank staff. They also used person centred software to monitor people's needs and staffing. The registered manager completed a monthly staffing analysis to show how many staff were on each shift in each unit and the number of floating staff. The report was sent to the local authority for monitoring purposes.
• People and their relatives told us there was enough staff available to meet people's needs. Comments included, "There are quite a bit [of staff], if you need someone, they come on time", "There is a wide number of staff and they get to know you personally which is part of the family feeling at this home", "[Person] needs a lot of help at the moment and staff are there for them. They're wonderful, caring and respectful" and "I think there are enough [staff]. It never takes more than three minutes for them to come. They have assigned staff per wing but they do circulate. One member of staff was moved to another unit but they still came to touch base with [person] in their own time, which I thought was lovely."

Using medicines safely
• Medicines were managed safely. Staff completed medicines training annually and undertook competency testing to ensure they had the skills required to administer medicines safely. The provider had recently introduced a software package that enabled staff to complete a virtual reality medicines round as part of their training.
• A Care Home Pharmacy Technician from the local authority audited the home 31 October 2019 and reviewed each person's medicines. The report noted there was 'good medicine management' at the home.
• Medicines, including controlled drugs, were stored securely, and only authorised staff had access to medicines. Medicines stocks we counted reconciled with the medicines administration records (MARs) which indicated people were receiving their medicines as prescribed.
• Staff followed the guidance in place for managing as required (PRN) medicines for each person and documented the reasons why they had administered the medicines. PRN protocols were audited weekly in response to pharmacist's report.
• People who self-administered medicines were assessed appropriately.

Preventing and controlling infection
• The provider had an infection control policy and procedure in place to help protect people from the risk of infection. Staff had attended training on infection control.
• We saw a number of checks completed to ensure a clean and safe environment. Each catering and domestic staff member had their own individual schedule with a cleaning checklist to confirm when a task had been completed
• Staff wore protective personal equipment such as gloves and aprons to help prevent cross infection.

Learning lessons when things go wrong
• The provider recorded incidents and accidents which included action plans to reduce the risk of re-occurrence and were signed off by the registered manager. Incident and accident audits recorded the incidents, the frequency of incidents that month for the person, if it was a fall, what aids were in place, if the incident was documented in the care plan and any action taken to reduce future incidents.
• In terms of learning lessons and improving the service, an area of focus for the provider was reducing the number of falls people had. The provider engaged a falls protection officer from the local authority to run workshops for people using the service and senior staff to try and get the balance right between people's choice and safety. The in-house physiotherapists were carrying out a 12 week programme of balancing exercises with people as suggested by the falls officer who will do follow up workshops in six weeks. The provider was also replacing carpets with a vinyl flooring and had invested in mops that leave the floor drier than regular mops to try and mitigate the risk of people falling in the home.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed prior to moving to the home to confirm these could be met by the provider in line with legislation and guidance. Assessed needs included a medical history, physical and mental health needs, social history, interests, other people involved with the person, how to they see their future, mobility and their sleeping routine.
• People, and where appropriate relatives, were involved in pre-admission assessments and these were used to form the basis of the care plan. This helped to ensure that staff had the information to plan the care people needed around their needs.
• People's protected characteristics under the Equalities Act 2010 were identified and recorded in people's care plans. This included people's cultural and religious needs. Wishes and preferences were also recorded.
• The staff regularly reassessed people's care needs and the risks they experienced so they could make changes to the planned care if needed.

Staff support: induction, training, skills and experience
• People using the service were supported by staff with the skills and knowledge to effectively deliver care and support.
• Staff completed an induction programme and new care workers were enrolled on the Care Certificate which is a nationally recognised set of standards that gives new staff to care an introduction to their roles and responsibilities. Staff were supported to keep their professional practice and knowledge updated in line with best practice through training, supervisions, annual appraisals and competency testing to ensure they had the appropriate skills to care for people.
• Supervision included ensuring staff had a working understanding of specific policies and guidelines such as preventing dehydration in hot weather, oral, auditory and vision care.
• Staff took part in daily handovers which included safeguarding issues, social events and training, so they had up to date information on people's current needs and the support they required. The provider also held team meetings for staff which provided an opportunity for staff to reflect on their practice and raise any issues.
• Staff said they felt supported by the registered manager and could approach them whenever they needed to. One care worker told us, "Anytime I don't understand something and I ask the manager or senior they are very patient with me to make everything clear so I can learn and work better."

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to maintain good nutrition and care plans recorded any specific needs such as a gluten free care plan, people's food likes and dislikes and where they liked to eat.

• People told us they enjoyed mealtimes. Comments included, "The food is very good with plenty of choice" and "I am happy and there is at least three or four lunch options and two options for supper. The kitchen has said if we want any fruit liquidised then we can." A relative said, "The food is very good here. They had taster sessions to improve the menu. The chef made a number of dishes for the residents to taste and got them to give their opinion."
• There were several different areas in the home for people to eat. Outside the main dining hall, there was a lunch menu that included pictures, ingredients and allergens as well as a large font menu. If residents chose to eat here, they had place names on the table which were moved around each day so people had the opportunity to sit with different people. Nuns, who lived in the convent part of the home, ate with the residents. One person observed that they thought this was 'remarkable'. However, it demonstrated the inclusive culture of the home.
• In the refractory we observed staff supporting people to eat in a gentle and patient manner and asking people how their food was. People were encouraged to eat independently as and when they could, but staff remained available to support as needed. Appropriate cutlery and crockery were provided to people so they could eat and drink independently.
• Where required, people's food and fluid intake were monitored, and people were weighed monthly. Changes in dietary intake or weight, along with identified nutritional risks, were referred to healthcare professionals.
• A nutrition audit was completed monthly that included people's BMI, weight, the increase or decrease in their weight, the risk level, the reason for risk, a plan to minimise risk and a check to indicate it is reflected in the care plan.

Staff working with other agencies to provide consistent, effective, timely care
• The provider worked with a number of other professionals to achieve positive outcomes for people using the service.
• We saw evidence in people's records of staff working together through input from other professionals including the continence nurse, physiotherapists, social workers, speech and language therapist (SALT) and the GP.
• A social care professional told us staff at St Mary's were, "Open, accommodating and transparent." Referring to a specific person, the professional said of their recent experience, "Staff know the [person] chapter and verse and what triggers [behaviours] and how they minimise them by recognising the signs."

Adapting service, design, decoration to meet people's needs
• The building was old but had been suitably adapted to meet people's needs. The home was over two floors with a lift servicing the first floor.
• The home was clean and well maintained. The provider had a five year refurbishment and decoration plan. The registered manager told us, "We have worked to produce an accessible building and grounds that can be enjoyed by all. We have used strong colours to denote key areas of the home to help those with visual impairments and improved the lighting in lots of areas. We have replaced flooring in areas and have an on-going plan to improve this everywhere, so residents can remain as independently mobile as possible."
• There was enough equipment to meet people's needs, for example hospital style beds, hoists, specialist bathroom equipment and hand rails along corridors.
• Communal rooms were bright and spacious and there was a garden with flower beds for people to enjoy. The home was nicely decorated, and the staff had made an effort to add homely touches, such as table cloths, fresh table arrangements and a range of ornaments and pictures.
• Communal areas had information boards that included upcoming events and what staff were working. People's artwork was displayed on the walls.
• People's bedrooms were clean and personalised to individual tastes, so they had familiar things around them.

Supporting people to live healthier lives, access healthcare services and support
• People's care records showed that they were supported with their healthcare needs as required. Staff made referrals to a range of professionals according to people's needs and they visited the home to see people and to advise on their healthcare needs. For example, we saw that people were seen by the optician, dentist, and speech and language therapist.
• People said their health needs were met. One person told us, "You call the nurse first of all. If it's urgent, they call the GP. He comes in once a week." Others confirmed they were supported with oral healthcare and one person said, "Yes they made contact with the local dentist for me. I can't think of anything that's not available here." All staff had to sign a form to indicate they had read CQC's guidance on oral health care in care homes and each person had an oral health assessment completed monthly.
• Relatives also made positive comments about people's health needs being met. They said, "The physio is absolutely first class. I've never met anyone as knowledgeable as him", "[Person] needs a hoist, help eating sometimes and physiotherapy. The GP is excellent and prescriptions are prompt" and "[Person] can see the GP every Friday and they make use of that. Staff are very good at offering things; the GP, food and teeth are all looked after."
• A healthcare professional told us, "They are very proactive. Any time I come they tell the issues they have been having and we discuss how they will resolve the issue. I couldn't praise the place enough. The staff are always professional."

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• The principles of the MCA were being followed. People's mental capacity had been assessed and best interests decisions had been made appropriately and as required.
• Where necessary, the registered manager had made applications for DoLS authorisations so people's freedom was not unlawfully restricted. Authorisations granted by the local authority and any conditions were kept on record and were part of the care planning so people received the care they needed.
• Where there were restrictions on people's liberty, the provider had followed appropriate procedures. We viewed mental capacity assessments for individual decisions such as the use of bed rails and sensor mats.
• Staff had attended virtual training and face to face training around the Mental Capacity Act and had a good understanding of the need to obtain consent before providing care.
• We observed people had the opportunity for choice and control in their day to day lives though being asked what activities they would like to do, what room they wanted to sit in and always being offered a choice of food and drinks.
• We saw where appropriate, people were able to come and go from the home. People who needed support told us, "I can't go on my own, but staff take me, even shopping", "Staff take you out or you can go out with a visitor" and "If I need to, I can go out with the organisers. I just got a new wheelchair, so I'll be going out a lot

more."

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as outstanding. At this inspection this key question has changed to good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• We observed people were well cared for by kind and caring staff who understood the needs of the people they were caring for. Every person, relative and professional we spoke with consistently spoke highly of the care provided at St Mary's. Comments included, "The staff here are all brilliant and their patience is amazing. They are always cheerful and always helpful" and "They run the home in the most friendly and disciplined way."
• The home was managed by a Christian religious order but managers were clear people of all or no faith were welcome to use the service. The registered manager and managing director lived on site and were very involved and knowledgeable about people living in the home and all that was happening in the home.
• There was a real sense of an inclusive and respectful environment for people and staff, so it felt like a family home and not just a care home. A relative observed, "It feels like a big family. I think it's unique here. It's outstanding! I don't think [person would] ever find anywhere better."
• We witnessed the staff sitting talking with people, laughing with them and complimenting them on things they had achieved. One person told us how staff made extra time to spend with them and said, "Occasionally if I want to chat, they'll come, and one or two [staff] on their break will pop in to say hello."
• Staff had undertaken training in equality and diversity and were aware of the importance of respecting people's individual needs and protected characteristics. The provider led by example by also respecting people's and staffs' protected characteristics. A staff member had just started parental leave as a new parent in a same sex relationship and the registered manager told us they were committed to ensuring everyone is treated fairly at all times.
• The registered manager made arrangements to ensure people and staff learnt about diversity and different cultures as well raising people's general knowledge about the world. The home held different theme days that celebrated cultures from around the world. For example, we saw evidence of dancers from Indian and Chinese cultures providing entertainment and the chefs cooking food from other countries for specific activities or events.

Supporting people to express their views and be involved in making decisions about their care
• People were able to express their views and actively make decisions about their care and day to day lives. People were involved in planning their care and were able to express their views through care plan reviews and resident meetings. People told us, "Oh yes, I'm very involved [in planning my care]. I self-administer medicines" Relatives said, "If [person] says they don't want something that's fine with [staff]. Their respect for personality is 100%" and "They're very helpful, respectful and they suggest things very gently, [as person] is losing their memory."

• People's care plans included information about their choices and preferences so that the staff were aware of these. We observed staff gave people choices in all aspects of their care, listened to what people said and respected their decisions. We observed when people had finished a lively crossword session, staff asked each person individually if they would like to go to tai chi and if not, where would they like to go. When they were supporting people to mobilise staff explained what they were doing. One person said they did not want to go to tai chi and said they wanted to play scrabble so the activities coordinator sat and played scrabble with them.
• Each person had a key worker who was responsible for their review and people signed their reviews to indicate they were in agreement with the care provided.
• Where appropriate people's relatives contributed to care planning to help ensure people's needs and wishes were met. One relative said, "They are so friendly and always try to do right by [person]. I can phone up and we work in tandem. I always know they're doing the right thing." The provider also had an online site so relatives could access information about people if they had people's permission.
• We saw useful information in the form of leaflets and posters were displayed around the home. Each month the home displayed information about a different topic on a board in a communal area accessible to people and staff to raise awareness and provide information on certain areas. Topics included flu, hydration, mouth care, sepsis and norovirus.

Respecting and promoting people's privacy, dignity and independence
• Staff respected people's privacy and dignity and encouraged people to maintain their independence. Some staff were 'privacy champions' and their role was to promote good practice around privacy with their colleagues.
• Staff told us they knocked on people's doors and waited for a response. When supporting people with personal care, staff did not wake people up to do this and when people were ready they asked people how they wanted to be supported. People had the opportunity to express a preference for a male or female carer and this was respected. A relative said, "[Person] needs a lot of personal care. They always look nice. This is one of the most respectful places I've ever been."
• People were supported to maintain their independence, but staff were available if needed. For example, people were given equipment to help them manage their meals independently.
• Another example of finding ways to safely promote independence was of a person who had impaired capacity and wanted to use their mobility scooter outside of the home. The home initially thought this was a high risk but worked with the person and the family to safely enable and empower the person to use their scooter in the community which meant staff were able to respect the person's wishes and contribute to the person being able to go out independently.

Outstanding ☆

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now improved to outstanding. This meant services were tailored to meet the needs of individuals and delivered to ensure flexibility, choice and continuity of care.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People lived fulfilling lives and were supported in innovative and creative ways to avoid social isolation and links with the community were developed. The provider had an activity co-ordinator who arranged a variety of activities on a daily basis. Activities included, school children singing, musicians, dancers, and animals visiting the home. The home had a chapel and mass was said daily. They also had a hairdresser and a manicurist to help people care for their appearance.
• People told us they could participate in activities if they wanted to. Comments included, "They do a lot. I go bowling on a Wednesday" and "I read, play board games and play card games." Relatives confirmed, "They have a reading group, reminiscing, music and movement, outings for lunch in small groups, walking groups, sherry parties and tea parties" and "[Person] can go to chapel whenever they want. It's very important to them. [Person] also likes to read and spend time on their own, but they are always encouraged to go out." People also had the opportunity to identify activities they were interested in. For example, one relative said, "They have a bucket list for people to do things. [Person] got to go to Buckingham Palace for the day."
• The registered manager told us they developed the Orangery Café after feedback from some people indicated they would like to meet for drinks after meals. As a result, the café has staff in it from 6:15pm every day except Thursdays when there is a pre-supper drinks gathering. The Managing Director also spent time identifying a simple to use coffee machine that was installed in the room. People enjoyed being able to use the machine independently and there was also a snack bar and ice cream freezer people could help themselves to. One person said, "Yes I do [like living here], it supplies my personal needs. I have my lunch in the Orangery café with one other person each day to accommodate my health needs. After last service of the day we get together in the café for drinks and fancies. There are also dogs and cats here and these are the tiny things that make it feel like home."
• In addition, people could reserve a table in the Orangery Café and invite guests to join them. We observed this during the inspection and saw staff set the tables nicely and checked to make sure people and their guests had everything they needed.
• The provider encouraged family relationships and community links, so visitors were always welcomed. They had guest rooms available for people who travelled a long distance. Comments included, "We can visit any time we want" and "There is fantastic management and the commitment is there. [Person] had their 80th birthday party here and they gave us the big room and arranged the facilities". We spoke with visitors who continued to come and visit although their relatives were no longer at St Mary's. They were very positive about the care their relatives had received when they were at St Mary's.
• Staff and a relative gave an example about how St Mary's went the extra mile to support relatives to remain in contact and to be close to each other. They told us how although the home does not usually

accommodate people under 65 years old, they made an exception to accommodate two relatives, so they could remain together. One person had additional mental health needs and some staff in the home undertook training to specifically meet the person's needs. When one of the people passed away, there was concern around how the other person who had only lived with the person who had died, would manage this. A relative told us, "Staff went out of their way to understand what was going on for [person]. [Staff] are very good at recognising what [the person] needs. After [the other person] died, St Mary's made [person] an associate of the Order which is not an onerous task but gave [person] a sense of validation and meant a huge amount to them. [Person is] very religious and it made them feel a part of their home."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• People received exceptional personalised care and were supported to have choice and control. Care plans were person centred and recorded people's preferences and staff were knowledgeable about the needs of the people they supported.

• People told us they were involved in contributing to their care plan. One person said, "I have a copy [of the care plan] and I correct it when necessary." Comments from relatives included, "Every night notes are written and checked and the next day everything is up-to-date" and "When [person] first came here they [contributed to their care plan] and they decided the important things. It's not set in stone and things have changed over time."

• Relatives felt staff were flexible and able to meet people's needs. They told us, "Staff are very good and listen well" and "More recently they suggested ways to help and that they could train up the staff instead of sending [person] to hospital."

• The registered manager told us how they tried to meet people's individual needs and provided an example of a person whose condition that meant others might not want to engage with them. The registered manager said they had taken measures to 'maintain [person's] dignity, ensure they did not become isolated from other residents and visitors, maintain their self-respect and general health. Measures included meeting with healthcare professionals to address the presenting issue and discreetly putting measures in place in [person's] bedroom to minimise some of the effects of the person's condition. This meant the person was able to interact with others without being self-conscious about their condition.

• We found several examples where staff had effectively responded to people's needs and proactively found new ways to support people to continue to live the life they wanted to despite changes in their needs. This included a person who had a condition that affected their stomach. They told us they no longer felt comfortable in the larger dining areas and their request to sit in the Orangery Café for meals was supported. Furthermore, each day they asked a different resident to join them for lunch. We observed this during the inspection and saw that the person's lunch was a pleasant social occasion although they now had the challenge of their current physical needs.

• Relationships between people and staff were based on mutual respect and finding ways to support people to do what they wanted to do safely. For example, one person who had a strong faith liked to take communion but had difficulty swallowing. To accommodate this, the bread was dipped into wine to soften it for the person, so they were still able to take part in this aspect of their faith. At present they are unable to manage the bread but are supported to have wine as part of their communion. This enables the person to participate in the service which was important and comforting to them.

• Some people who were supposed to be having supplemental shakes were refusing them as they didn't like the taste. Staff sourced a recipe book that used the shakes and had a cookery session with people where they successfully made chocolate brownies as an alternative to the shake in drink form. This meant people were getting their required supplements in a way that met their preferences.

• Daily handovers helped to keep staff updated about any changes to people's needs and updates were recorded in the care plan.

• Staff members at all levels were incredibly responsive to people's needs throughout the day. People were

relaxed and happy and the staff consistently checked if there was anything else they needed. One person had a table dedicated to their puzzle and said to one of the staff they wanted to see the managing director who we witnessed ask the person how they could help and the person requested a larger table for their puzzles, which the managing director said they would arrange.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• Care plans included information about people's communication needs, including if they required assistive aids such as glasses or hearing aids. One staff member completed some additional training around caring for hearing aids and provides regular support in this area to anyone requiring it. People's glasses cases were labelled to clarify if the glasses were for reading or distance.
• Anything such as care plans or meeting minutes could be printed out in large print. Some people requested documents emailed to them, so they could read it on their computers. Every resident received a copy of the monthly newsletter which was produced in large print with clear pictures.
• Staff were very responsive to one person who had a degenerative condition that affected their communication. They had regular visits from a speech therapist and the care plan recorded their communication needs. Initially the person used a touch screen communication board, but this was not always their preference. Staff began to ask yes and no questions and found that the person responded better to communicating in this way. When the person talks, staff listen carefully so as not rush them. On occasion the person also wrote things down so staff ensured that they always had paper and pens available to them. This meant the person had options about how they would like to communicate and helped to ensure their views were heard.

Improving care quality in response to complaints or concerns
• The provider had procedures in place to respond to complaints. People and their relatives knew how to make a complaint and felt comfortable raising concerns. However only person we spoke with had ever made a complaint and they confirmed it was dealt with appropriately.
• The complaints log included future action/ change needed and lessons learned for each complaint. Complaint forms had a description of the complaint and detailed action taken. If required, notes regarding safeguarding alerts and CQC referrals are attached and a follow up review is signed to indicate if action taken as a result of the complaint was effective.
• How to make a complaint information was available on communal notice boards in the home and there was also a suggestion box so people could easily make their views known.

End of life care and support
• Staff had end of life training and supported people to make decisions about their end of life care. These were recorded in people care plans along with 'do not attempt cardio pulmonary resuscitation' (DNACPRs) if required.
• The home had good links with the local hospice and were able to support people who wished to remain at St Marys to receive end of life care.
• Staff were sensitive to the needs of both people and their families at this time. Relatives had access to guest rooms at the home should they wish to stay nearby to people at the end of their lives.
• Additionally, the home participated in 'Coordinate My Care (CMC)' which is information about how they would like to be treated and cared for, which is on a data base other healthcare professionals such as the GP, ambulance service and hospitals can access, so they have clear guidance on people's care preferences

and wishes.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People and their relatives were very satisfied with the care provided.
• The registered manager promoted an open culture and was available to people using the service and staff. People felt the registered manager ran the home well. Comments included, "[The registered manager] is very nice. If it wasn't for them, I wouldn't be here", "[The registered manager] is very marvellous, organised, human and they take great care of us. You can do things as you like here. It's a great blessing and there is great freedom here which I like" and "There's always someone to do what you need." Relatives also gave positive feedback about the registered manager and staff saying, "They are all wonderful", "[The registered manager] is remarkable", "I think they're doing a fantastic job. They're always trying something new – the lift, a café, a new office and even a bucket list where the residents can put down a wish and the sisters/staff will try and make it happen" and "I think it's extremely well run."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The registered manager understood their responsibility around the duty of candour. They were open about sharing information during the inspection. We saw evidence they acted in a transparent manner when things went wrong and where appropriate relevant people were notified of incidents including the local authority, people's family and CQC.
• People and their relatives knew who the registered manager was and felt they could raise concerns. One relative said, "As soon as I said something, it was put right. Never had to say anything more than once."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The registered manager and staff team understood their roles and had a clear management structure.
• Staff felt supported by the registered manager and there was good communication within the staff team through handovers and team meetings. Comments from staff included, "The managers listen. If you ask for advice or something needs to be done, they're really good."
• The provider had processes to monitor the quality of services provided in the home and make improvements as required. Audits completed by the registered manager included weekly medicines audits for each person in the home and monthly environmental audits of the home. Senior staff audited all care plans over a four month period to confirm they were up to date and recorded when the six monthly review was due. The provider was discussing with the software company how audits could be electronically

recorded and a report run on the system so the registered manager had a clear overview of care plan audits. Feedback from audits was shared with the staff to improve care plan recording.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• People and staff were engaged in how the service was run. People attended regular meetings about the care the home provided and contributed their views on the care they received. Resident meetings were held three times a year. The home used to have regular meetings for relatives but very few people showed up. When the provider wrote to relatives to see how to involve them, relatives said they were happy with visiting their relatives and raising any concerns at that time.

• Staff, nurse and management meetings were also held regularly to give staff and management the opportunity to share challenges and good practice and make improvements for both people living and working in the home.

• The provider carried out several surveys during the year and the feedback was positive about the care provided by St Mary's. We saw the dining room changes survey in August 2019 comments were being addressed through an action plan. All responses from professionals in April 2019 were either good or outstanding. After people had respite care at the home, a discharge summary was completed which also all confirmed the care in the home was excellent.

• The home was engaged in a number of community events including visits from school children, Church of England priests and Roman Catholic nuns from the local area visited the home weekly. Local people were being invited to St Mary's to share in Christmas lunch. People from the home had recently been to a local school pantomime, went to the Brompton Oratory for tea once a month and attended a social club for older people. Two senior staff attend the local friends and neighbours scheme as part of maintaining links with the community.

Continuous learning and improving care

• The provider had systems for assessing, monitoring and mitigating risk and improving the quality of the service. Areas for improvement were recorded with an action plan of how to implement improvements. Incidents and accidents were monitored and analysed to reduce their likelihood in the future.

• The registered manager was a nurse and had completed a 'My Home Life- Professional / Leadership Support and Development Programme' course in 2019 and attended provider and registered manager forums in two local authorities to keep up to date with current best practice.

Working in partnership with others

• We saw evidence the provider worked with other professionals including the GP, optician, audiologist, physiotherapists, dietician, speech and language therapists and palliative care nurse.

• Where appropriate they shared information with other relevant agencies, such as the local authority, for the benefit of people who used the service.