Poor Servants Of The Mother Of God

Maryville Care Home

Inspection report

12-14 The Butts
Brentford
Middlesex
TW8 8BQ

Tel: 02085607124

Date of inspection visit:
29 March 2016

Date of publication:
13 June 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 29 March 2016 and was unannounced.

The last inspection was 25 October 2013 at which time the service was meeting the assessed standards.

Maryville Care Home is part of the Frances Taylor Foundation and is registered to provide accommodation and personal care for up to 39 adults over three floors. The service was at capacity on the day of the inspection. Some people who used the service were living with dementia and others required nursing care.

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 2008 and associated Regulations about how the service is run.'

We saw the majority of the medicines were stored safely, however we observed an unsecured fridge with medicine in it accessible to people who used the service and visitors.

Staff were sufficiently deployed and appropriately trained.

The service had a safeguarding policy and procedures in place.

The environment was clean and well maintained.

There was evidence of regular meetings with staff, people who used the service and their families.

Staff had regular supervisions and yearly appraisals.

Health needs were being met through assessments, monitoring and support from the relevant professionals.

Staff were kind and caring. They knew the people who used the service well and were able to meet their needs.

The majority of people had person-centred care plans and we saw evidence that staff followed them to meet people's needs.

The service did not have an activities co-ordinator. There were activities but staff did not always feel they had enough time to support people with activities.

People who used the service, staff and relatives told us the manager was approachable and they could raise

concerns with them.

Monitoring and auditing records were well maintained.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medication was administered in a safe and caring manner.

However, there was an unlocked fridge in the communal lounge containing a vitamin supplement and folic acid.

We made a recommendations to address the above point.

There were risk assessments and evidence of policies and procedures to keep people safe.

There were sufficient numbers of appropriately trained staff.

Safe recruitment practices were followed.

The service was clean and well maintained.

Is the service effective?

Good

The service was effective.

Staff had the relevant training to support the people who used the service.

There was evidence of team meetings, supervisions and appraisals.

The service made use of community organisations to improve their skills and knowledge.

The service was working within the Mental Capacity Act 2005 and there was evidence of consent to care and treatment.

People's nutritional needs were met and food was prepared freshly each day.

The needs of people who used the service had been assessed, monitored and met appropriately.

The service engaged with the relevant professionals to ensure healthcare needs were met.

Is the service caring?

Requires Improvement

Most aspects of the service were caring, however we saw an open door during personal care.

At times we observed staff did not always offer people choices and that levels of engagement were an issue in some instances.

People who used the service and their relatives told us staff were kind and caring.

Staff were attentive and offered explanations.

Staff were familiar with peoples' needs and able to meet them in a caring manner.

Is the service responsive?

Good

The service was responsive.

People who used the service had individual, person centred care plans that addressed people's needs.

Staff and people from outside the service provided support with activities. We saw evidence of people engaging in activities and the people we spoke to told us they enjoyed the activities.

There was a complaints procedure and people felt able to approach the manager with any concerns.

Is the service well-led?

Good

The service was well led.

People who used the service and their relatives told us they liked the service.

People were able to give feedback to the manager.

Records for monitoring and auditing were well maintained.

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.

The inspection took place on 29 March 2016 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. The expert-by-experience on this inspection had personal experience of caring for someone who was living with dementia and used care services.

Prior to the inspection we looked at all 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.

During the inspection we spoke with six people who used the service, seven relatives and a visiting health professional. We observed staff interaction with the people who used the service. We interviewed nine staff including the registered manager, two nurses, care staff and the cook.

We looked at the care plans for 12 people who used the service. We saw files for five staff which included recruitment records, supervision and appraisals and we looked at training records.

We looked at medicines management for people who used the service. We also looked at records including maintenance and servicing checks and audits.

After the inspection we spoke to the GP, the placements team in the local authority and the Dementia Institutional Care Enhanced Service (DICE) to gather information on their experience of the service.

Good

Is the service safe?

Our findings

Medicines were administered safely. There were locked medicines rooms with secure, locked trolleys. There was a controlled drugs cupboard and record book.

However, we saw that the fridge in the communal lounge on first floor was unlocked and contained prescription medicine for a vitamin supplement and folic acid. This was poor practice as people who used the service or visitors could access it.

We observed a nurse administering medicines in a safe and caring manner. Individual preferences were taken into account and we saw one person taking their medication with a biscuit instead of fluid. The nurse explained they gave this person more time to ensure their medicines were administered in their preferred way.

The medicines administration records (MAR) were clearly printed and signed. Each MAR sheet had a photo of the person and basic details including a list of medicines and their functions. However we saw a GP had changed the time on one MAR sheet from 17:00 to 16:00 but had not signed it.

Staff who administered medicines attended training yearly.

Records were generally well managed. We saw a wound care plan which had evidence of input from the tissue viability nurse.

Some care plans did not always link effectively to risk assessments. For example some people scored as being at risk of pressure sores but the pressure equipment in use was not documented in the care plan itself. However the risk assessment was available to all staff involved in the person's care and the pressure equipment was present and in use.

There were a range of risk assessments with the relevant dependency or risk scores as appropriate. These included risk of falls, skin care (Waterlow), nutritional status (Malnutrition Universal Screening Tool), continence assessments and general dependency assessment scores. Scores were all updated monthly up to February 2016.

People living in the service, told us, "I feel safe here" and "Yes, I feel safe. I am determined and I feel safe anywhere, but it's a safe place"

The service had safeguarding adults and whistleblowing policies and procedures in place. There was evidence of safeguarding training within the last year and staff were able to provide some definition of abuse and/or neglect. All staff said they would report any safeguarding concerns to the manager. Some were unsure who they would contact if the manager was not responsive but said there was information and phone numbers in the office if they needed to refer to them.

We observed a sufficient number of staff on each floor. There were three care staff on each floor and one registered nurse on duty. The manager said they observed staff numbers and we saw evidence in the minutes that staffing was discussed in the nurses' meetings.

Staff had differing views about whether staffing levels were adequate. Some felt staffing levels were appropriate but others commented that the home needed more staff to cover for absences and sickness. Additionally some staff felt that given the level of physical care many people required, there was not enough social time to spend talking with people.

The manager told us that from 01 April 2016, care staff would increase from three to four staff on each floor. They told us this was in response to people who used the service becoming older, frailer, and therefore more dependent. By increasing staffing, people's needs could be better met.

The service followed safe recruitment practices and we saw evidence in staff files of applications, Disclosure and Barring Service (DBS) checks and references.

The manager ensured that staff and people who used the service were updated about any health and safety issues, and included this as a standing agenda item in their meetings.

All areas of the home were clean, well maintained and free of any hazards. Both visitors and professionals told us there was a good standard of cleanliness. Communal bathrooms and toilets were well equipped with modern fittings for disability use and access. There was liquid soap dispensers and information on hand hygiene clearly visible. Communal toilets and bathrooms had emergency cords that were accessible from the floor.

There were records of health and safety audits for care plans, hoists, bedrails, bed sensors, water temperature, emergency lighting and Portable Appliance Testing. The service had records for a fire risk assessment, fire drills and fire alarm system testing.

We recommend that the provider ensure all medicines are stored safely.

Good

Is the service effective?

Our findings

We looked at five staff members' files and saw that staff had an induction when they started working for the service. One of the newer members of staff outlined the induction programme that consisted of a range of training modules and a period of supervision and shadowing. Staff had training that included health and safety, moving and handling, safeguarding, fire safety, food hygiene, and Mental Capacity Act training. We saw records to indicate staff had attended safeguarding and Mental Capacity Act training in the last year.

The staff files we looked at had evidence of yearly appraisals. We saw supervision records indicating staff had the opportunity to discuss any concerns and to develop their skills and training.

Staff were supported to develop good practice. Training, supervisions and appraisals provided staff with the knowledge and skills to provide effective care to the people who used the service.

There was evidence of good communication. We saw minutes for a number of meetings including meetings for nurses, team leaders, staff, people who used the service and relatives. Relevant topics were discussed and acted on. Additionally we saw a newsletter from January 2016 that went out to people who used the service and their families which kept them updated on events and activities in the service.

The service had good links with community organisations such as the Alzheimer's Society and Age Concern. Since January 2016, a person from the Alzheimer's Society had visited the service three times in both the afternoon and the evening so staff and the families of the people who used the service could attend the training they were delivering. One relative told us they attended one of the training sessions about Alzheimer's disease and dementia two weeks ago and said, "It was a great evening where we could say 'What do you do?'" (regarding specific situations related to dementia).

As the response from the training sessions with the Alzheimer's Society was positive, the service contacted Age Concern. They are arranging for Age Concern to deliver training around depression to increase staff and relatives' understanding of depression and how to provide better support to people.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Four people had authorised DoLS applications. Files with DoLS application requests had mental capacity assessments and best interest

assessments.

A healthcare professional we spoke with was aware of DoLS referrals being made appropriately. They worked with people who lived with dementia and told us the service was meeting people's needs in terms of their mental health and if the person could not wait for a scheduled visit, the service would contact the Dementia Institutional Care Enhanced Service (DICE). The professional said, "They know their residents well. If there are any changes they will alert us." and "They know backgrounds, histories and families and are very easy to communicate with."

We saw good evidence of consent to care and treatment in all the care files seen. All the care plans were signed either by the person who used the service if they had capacity, or by their next of kin if the person was unable to sign.

Most care plans were current and signed which demonstrated involvement by people who used the service in the care planning process.

All the files we looked at had Do Not Attempt Resuscitation (DNAR) forms located at the front of the care files for easy access. All were correctly and fully completed, indicating whether the resident had capacity or not. All were authorised by the GP and dated within the last year with evidence of consultation with the resident or next of kin if the resident lacked capacity or was unable to sign.

Meals were cooked freshly each day in a central kitchen and served in bright, cheerful dining rooms on each floor that had kitchenettes attached to them. Residents' comments on mealtimes included: "Meals are good" and "Regular, on time and varied".

There was no menu on display apart from that day's meal choices. Staff spoke to each person individually prior to mealtimes to ask which meal option they preferred. We were told people could change their minds before being served if they wanted to. The evening meal was at 5:30pm and we were told people could order food later if they wished. Tea and coffee was served mid-morning and mid- afternoon and jugs of juice and water were available in the lounge. People were also served hot or cold drinks on request.

The kitchen was clean and well ordered. The cook reported that they talked to the residents on each floor every three months to get direct feedback and suggestions on catering. They also received feedback from the manager after resident and relatives' meetings. For example, the kitchen recently replaced pork with chicken as it was easier to eat and they re-introduced Irish stew.

The kitchen did not maintain any central file or records on dietary needs and preferences for each resident and relied on personal knowledge and information from care staff. The cook acknowledged that it would be a good idea to keep a more formal record of each resident's dietary needs and preferences in the kitchen.

The care files had separate nutrition care plans which recorded nutritional status and dietary needs such as the need for fortified or pureed food, swallowing difficulties and assistance required to eat and drink. There were also some indication of food preferences, likes and dislikes and routines (ie times and places where meals were to be taken.)

MUST scores were recorded and updated monthly to show weight and BMI. If weight loss was noted the appropriate action was taken with referrals to the dietician and Speech and Language Therapy (SALT) team as required. We saw evidence of responsive monitoring in one care plan where food supplements had been introduced until the person's weight loss was recovered.

People were supported to maintain good health and had access to a number of professionals. The GP visited the service once a week. We saw a range of correspondence and notes documenting input and interventions from various health care professionals, hospital appointments, referrals, test results and discharge notes.

A log of incidents, accidents and falls was maintained and showed a summary of the incident, any injuries sustained and if the relatives or GP was informed. The manager noted that falls had reduced in the last 18 months since the service had introduced sensory equipment.

People who used the service told us, "The GP comes every Saturday - my glasses I deal with at the high street. The chiropodist also comes. I go for (health appointments) and an ambulance comes for me and I get support with that" and "Doctor, specialists; they arrange some of it". One person said: "Occasionally you get checked up - like my hearing - and you can always ask if you are not feeling well. They are professional and speaking as a professional - I am speaking in all the senses- like the way they look after (fellow resident) and they are very good" Another person told us they saw the chiropodist and the surgeon. They explained they had undergone major surgery and felt they had been supported throughout the process.

We saw that individual bedrooms were bright, cheerful and comfortable. All rooms had en suite facilities with a shower, toilet and hand basin. Bedrooms had call bells which could be used if required and which were all within reach. We saw flat screen televisions and personal items such as pictures in bedrooms. A relative told us that it was "Wonderful here that they encourage you to make your mum's room as much like it was at home."

Some rooms overlooked or backed onto the well maintained, landscaped garden which was accessible for people who used the service.

Much of the home had recently been redecorated and there were good quality furnishings and flooring along with pictures and art exhibits on the walls. There was a sensory room with a water feature, soothing lighting and soft music. There were a variety of communal areas on each floor, a communal lounge and dining room with attached kitchenette, all with modern fixtures and fittings. There was an activity room on the first floor which was used for arts and crafts and other meetings.

The service had good signage and we saw individual signs for one person who found it difficult to navigate around the building, which showed them the way to their bedroom.

Requires Improvement

Is the service caring?

Our findings

Staff were seen to knock on closed doors before entering and said they always respected privacy and dignity by ensuring that people's choices were respected. Staff told us doors were closed when delivering personal care. However we saw one member of staff supporting a person to have a bath and the bathroom door was open (although neither the person not the bath were visible from the door). People who used the service told us, "I have my space when I want to and they don't infringe on it", "My room is very private and quiet and nice" and "My room and my loo (is private); even though the door is open they knock before entering."

Staff were not always proactive in offering choices to people and we did not always see staff offering a choice of what to watch on TV or what music to listen to.

People who required assistance at lunchtime were mostly helped patiently and gently by staff and supported at the person's pace. However we did see one instance where staff supporting a person with lunch engaged poorly with little eye contact or conversation.

Most people who used the service told us they were treated kindly and listened to. One person said, "Yes, I feel like I'm at home" and another said, "Yes they are (kind), they deal with all of us." A third person's opinion was less positive however. They told us, "Staff only come for money. They pick up the money and they go home" but this was not reflective of what we observed. People also told us, "They are very amicable and attentive - they are great", "Mostly alright", "They're very understanding. I can't complain about staff in any way. They may take some time but they are very understanding" and "They are excellent - I worked in hospitals all my life and I can assess fairly."

Relatives commented, "Great warmth to it - they know their residents.", "They treat them as individuals. They know her.", "It really feels like a home for the people who live here." and "Maryville is wonderful – the atmosphere is lovely - just like a real family." One relative noted, "They care for relatives as well as residents and give them support too when they need it, they're really very kind and caring."

We spoke to a healthcare professional who said that the service was good and that staff were caring and attentive to residents. They advised communication with the manager, nurses and care staff was open.

We observed that staff generally displayed a gentle and patient approach to caring for people throughout the day. They were cheerful and good-natured. Staff communicated with people clearly and appropriately, making eye contact, offering choices and explaining what they were doing when assisting people. They were attentive when people needed assistance and understood how best to talk to different people who used the service.

There was a good level of engagement, however we did observe there were periods of time when people were left sitting unattended in communal areas or their rooms. The manager told us there was a planned increase of staff from 01 April 2016.

Staff were clearly aware of people's needs, routines and behaviour and were able to explain how they supported different residents. There was a key worker system which required the key worker to update care plans and undertake the monthly evaluations. This meant that care staff were familiar with the details in the care plans and kept up to date with current needs and any changes needed to care and support.

Families and relatives were able to visit when they chose to. All relatives said that the staff always made visitors feel welcome and were responsive and helpful.

Most care files had information relating to end of life planning. We saw end of life care plans, a personal wishes form and a living will. Care plans usually stipulated funeral arrangements and who should be involved in the event of a death.

Good

Is the service responsive?

Our findings

Each person had an individual and well maintained care file which contained profiles, pre-admission assessments, care plans, daily routines, risk assessments, monthly evaluations, documentation of input from other health professionals and daily logs. Monitoring charts, recent progress notes, wound care documentation and activities records were kept in separate folders.

People's needs were identified prior to moving into the service. We spoke to the relative of a person in the process of moving into the service. The relative told us they had completed a pre-assessment form, provided relevant documentation, for example that they had the Power of Attorney (POA) and had discussed medicine and the menu with staff. Their family member had visited the service and they had begun to bring personal things for their bedroom. The relative indicated the assessment had been a positive process and said "(The manager) has been very welcoming and understanding."

The care files contained information about lifestyle and background such as personal history, past employment, hobbies and family background. Staff were generally familiar with these details which they felt helped them to empathise and communicate with people who used the service.

There were a range of care plans relevant to individual need which addressed physical, medical and psycho-social needs. This included spiritual, cultural and social support. Each care plan indicated the desired outcome and the action required to achieve it.

Care plans contained an appropriate level of detail and were person centred with evidence of preferences, routines and any relevant risk factors. For example we saw records of waking / sleeping preferences. One person requested that staff did not do night checks. Another person requested personal care early in the morning.

Physical, behavioural and medical needs were well documented. One person with impaired vision had detailed instructions on how best to communicate and where to place cutlery at mealtimes so that it was within reach.

At the time of the inspection, the service was undertaking an audit to ensure people's care plans were reviewed. The ground and second floor care plans had been audited in January and February 2016 and they were in the process of auditing the first floor care plans.

Some, but not all people we spoke with, were aware of their care plans. People who were aware of them said they did contribute and we saw evidence of people signing their care plans. We spoke with relatives who were involved in the care plans. One relative told us their family member's care plan was reviewed about a month ago and that they and the service "worked together."

The service did not have an activities co-ordinator but did have a programme of daily activities that staff supported people to attend. These tended to be group activities and we did not see arrangements for one

to one activities. Some staff felt there was not enough staff to provide adequate support for activities.

There was a schedule of activities for each day posted on the walls throughout the service but this was a small sheet which would have been difficult for some people to read. Activities for each person were recorded in an activities folder.

People told us, "I go to bingo" and "I go to massage / aromatherapy. She is really nice to people." Another person told us they could do "Any (activity) I choose. I wanted to do art but they were full."

On the day of our inspection, we saw people actively engaged in playing bingo. Other activities included a volunteer drama group, evening foot spas, chair-based exercises, aromatherapy and coffee mornings. There was a room used for art and we saw evidence of people's art displayed. One relative ran a weekly art class. We also saw evidence of cultural evenings where a particular country was celebrated through food and quizzes etc.

Overall, there was evidence of a number of options for activities and the people we spoke to told us they enjoyed the activities they attended.

We saw a complaints folder. The last two complaints were in January 2016. The manager investigated and responded appropriately to the complaints in writing within five days of receipt. One complaint was about a person losing personal belongings in the grounds. The manager responded appropriately to the concern and assured the relative staff would walk around the ground every evening to check for any personal belongings and ensure they were returned to the person.

Good

Is the service well-led?

Our findings

People we spoke with told us, "I like everything. I'm happy and if I don't like anything I mention it", "The manager is nice" and "(I could) easily be at home. I don't think they can be any better than they are…we are looked after." The manager told us, "(I) always say to residents this is your home, how can we make your home more your home?"

One relative told us they visited the service every day. Regarding how the service was run, they stated, "As far as I am concerned it's dealt with very professionally and in a human way." Another relative told us they had the manager's mobile phone number and they were "very approachable" and that there was "good communication" from staff who were "very good and very kind."

Staff told us that there was an open and positive culture in the service and staff worked well as a team. They felt well supported by senior staff and management and were confident that they could raise concerns or queries at any time.

There was an interim deputy manager in post at the time of the inspection as the service was in the process of advertising for a deputy manager with a registered nursing qualification.

The manager knew the people who used the service and was able to identify individual needs. Staff told us the manager was visible and approachable, and was on the floor every day to observe and to speak with staff, people who used the service and relatives.

The manager was accessible to families and responded to any issues raised by relatives as evidenced in the complaints file and by relatives we spoke with. The manager attended family and resident meetings and provided feedback to staff. We saw evidence of this in the nurses' meeting minutes.

Surveys had recently been sent out to families and the feedback was expected shortly. The service also provided a quarterly newsletter to keep families and residents informed and updated about the service.

Each staff member's training was recorded and discussed in supervision. The manager told us they worked with staff to improve performance. For example, last week a member of staff asked for more information on tissue viability and they have since been booked to attend training.

In terms of developing staff, the manager had recently begun to use training workbooks as they considered that staff would be required to take more time to reflect over written answers in a workbook which would assist staff to absorb the information better. We saw training and the workbooks discussed in the nurses' meeting minutes as part of how to improve training.

We saw evidence of regular meetings for staff, people who used the service and relatives. Residents meetings included items about activities, health and safety and menus. This gave people who used the service the opportunity to voice their opinions and raise any concerns.

The cooks spoke to people who used the service about the menus and completed an audit every three months. The last menu audit was in February 2016.

The service had resource packs on topics such as dementia that staff and families could access for information on how to support people living with dementia.

There were good local links. We spoke with the placements team in the local authority and the Dementia Institutional Care Enhanced Service (DICE). Feedback from the professionals was very positive. One professional told us "They are very, very good. They know what we're there for and they know their residents." There had been no safeguarding alerts raised and the local authority did not have any outstanding issues.

Maryville is part of a larger organisation called the Frances Taylor Foundation. The manager attended managers meetings with colleagues from other services. One the day of the inspection, a manager from another service was undertaking an audit of Maryville that was completed every two months. This provided extra support to ensure the service was monitored appropriately.

The above evidence indicated that the manager had a good understanding of the service and that the service was being well-led at the time of our inspection.