Poor Servants Of The Mother Of God

Maryville Care 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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Maryville Care Home is a residential care home over three floors, providing nursing and personal care to up to 39 people, and was at capacity at the time of the inspection.

People's experience of using this service and what we found
During the inspection we observed there were not always enough activities or meaningful activities to engage people and interest them. We recommended the provider ensure there are a range of activities that meet the needs of all people using the service.

People and their relatives told us they were satisfied with the service provided.

There were systems in place to identify risks. Safe recruitment procedures were in place and there were enough staff on duty to meet people's needs. Staff followed appropriate infection control practices to help prevent cross infection.

Staff received supervisions, appraisals, relevant training and competency testing to support them in providing safe and effective care to people. People's needs were assessed to ensure these could be met. People were supported to maintain health 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.

Families were welcomed to the service. There was a complaints procedure in place and people felt able to raise complaints with the registered manager. People, relatives and staff reported the registered manager was approachable and listened to their concerns.

The provider had systems in place to monitor, manage and improve service delivery and to improve the care and support provided to people.

Rating at last inspection
The last rating for this service was requires improvement (published 28 December 2018). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

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?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

Maryville Care 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 as personal experience of using or caring for someone who uses this type of care service.

Service and service type
Maryville Care 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. This included the last inspection report and notifications received from the provider. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection

We spoke with seven people who used the service and four relatives about their experience of the care provided. We spoke with eight members of staff including the registered manager, deputy manager and care staff. We also spoke with a visiting healthcare professional. We observed people's interactions with staff. We reviewed a range of records. These 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.

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 requires improvement. At this inspection this key question has improved to good. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management

• At the last inspection we saw a sluice room door was open when it should have been locked and the main door to access the kitchen and laundry room were closed but not locked. Immediate action was taken at the time of the inspection. At this inspection we found the environment was safely maintained so three were minimal risks to people.

• The provider had systems and processes in place to help keep people safe including risk assessments. We looked at risk assessments for four people. One person's records had a 'nutritional needs' care plan which provided an action plan on how to support the person, and although some of the actions would help to reduce risk, the care plan did not make explicit what the risks were and how to manage them. For example, what the trigger would be to refer the person the GP or dietician. The registered manager told us they would address the concerns and make the risks and the risk management plan explicit.

• Risk assessments were updated as required and where appropriate referrals were made to other services such as the physiotherapist or Speech and Language Team (SALT).

• 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 made checks to ensure the environment was safe and well maintained. These included environmental risk assessments and equipment checks. Maintenance and cleaning checks were up to date. Where concerns were identified they had created an action plan for improvements.

Systems and processes to safeguard people from the risk of abuse

• There were systems and processes to protect people from abuse and people told us they felt safe. People said, "I am safe. I am so happy at night. I know someone is here" and "There is always people around."

• The provider had relevant policies and procedures for safeguarding. Staff had completed appropriate training and knew what action to take to keep people safe.

• There had been no safeguarding alerts since the last inspection, and this was confirmed by the local authority. However, we could see from previous alerts the provider had raised safeguarding alerts as required and undertook appropriate investigations that included outcomes to be used to improve service delivery.

Staffing and recruitment

• People told us there was enough staff and staff responded if they rang their call bells. Comments included, "I'm sure there is enough [staff], "I just ask, and somebody comes" and "[Staff come quickly." A relative told us, "Generally [there is enough staff]. At times they can be pushed due to annual leave."

• We observed there were enough staff on duty to support people's needs safely. There were staff available in each communal room.

• The provider followed safe recruitment practices to help ensure only suitable staff were employed to care for people using the service.
• New staff members undertook an induction, so they knew how to work safely with people living in the home.

Using medicines safely
• Medicines were managed safely. A Clinical Commissioning Group (CCG) pharmacist reviewed the home's medicines management in October 2019 and found medicine management was good overall. We saw the provider had addressed any issues raised in their action plan.
• Staff completed medicines training annually and undertook competency testing to ensure they had the skills required to administer medicines safely.
• Medicines were stored securely and stocks we counted reconciled with the medicines administration records (MARs) and PRN (as required) medicines protocols were in place. This indicated people were receiving their medicines as prescribed.
• Medicines audits were completed monthly.

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.
• Staff wore protective personal equipment such as gloves and aprons to help prevent cross infection.
• Checks were completed to ensure a clean and safe environment.

Learning lessons when things go wrong
• Incident and accident records recorded the actions taken and care plans were updated accordingly to reduce the risk of re-occurrence. The provider was also completing separate analysis of infections and falls which recorded common themes and was signed off by the registered manager. There was an additional audit completed monthly which provided a summary of action taken collectively for all falls. These provided an overview and were used to reduce future incidents.

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.

Adapting service, design, decoration to meet people's needs
• The home's environment was not always adapted in a way to make it accessible to people and promote their independence. For example, peoples' bedroom doors had a number and a name on them, but otherwise were not distinctive from each other to help people to orientate themselves. We also saw that some, but not all, activity boards had activities in writing only and lacked visual cues for people who many not be able to read the signs.
• However, the deputy manager showed us an action plan for how the service was planning to make the home environment more dementia friendly. We saw evidence that they had already ordered wall murals for different areas of the home that included a memory café, seaside and sweetshop. We also saw they were in discussion with the company about purchasing personalised door murals for each person's bedroom door and planned to have this completed within twelve weeks. We will check this at our next inspection.
• Additionally, there was a reminisce area people could access, a sensory room, an activity room for painting and crafts, garden, chapel and people's rooms were personalised to their own tastes so they had familiar things around them. Display boards with information such as what staff were working was displayed in communal areas. Specialised crockery and cups were also used to promote peoples' independence.

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. Assessments involved gathering information from the person, their relatives if appropriate, and other professionals such as a social worker and were used to form the basis of the care plan. One person said, "They always assess you to see if you are right to come. I had a long interview about an hour".
• Assessed needs included mental and physical health needs, mobility and social skills. People's protected characteristics under the Equalities Act 2010 including cultural and religious needs were identified and recorded in people's care plans.
• Staff regularly reviewed people's care needs so they could make changes to the planned care as required.

Staff support: induction, training, skills and experience
• People were supported by staff who had the skills and knowledge to effectively support them. Newly employed 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.
• We saw evidence, and staff confirmed, they were supported to develop their knowledge and skills through relevant training. We saw the provider had arranged with the local NHS speech and language team training

around thickeners and dysphasia and completed training with the local authority for diabetes, pressure sores and falls. The deputy manager was a registered trainer and undertook dementia training with the staff team.
• Staff had undertaken training around dementia care and had become dementia friends which is part of an initiative by the Alzheimer's Society to raise awareness around the experience of dementia.
• Additional support was provided through supervisions, appraisals and competency assessments to help ensure people had the required skills to care for people. Staff attended team meetings which provided opportunities to discuss their practice and there were handovers between shift so staff had up to date information on people's current needs and the support they required.
• Staff were positive about support from the registered manager and told us, "[The registered manager and deputy manager's] doors are always open and it doesn't matter what time or what issue you have they always listen."

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 dietary needs such as fortified foods. People were satisfied with the menus and one person told us, "[Staff] come the day before to ask what you want. The food is lovely. There is no end to the tea I drink."
• The kitchen staff knew people's needs and specific diets such as diabetic or pureed which were recorded on the menu request forms against individuals' names. Menus were updated every couple of weeks and feedback was received verbally through the care staff.
• 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, for example the dietician or SALT team.

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 from people's records visits from other professionals were recorded and advice given acted on.

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 people told us the doctor was called when required.
• The provider used national guidelines for oral care for adults in care homes, had an oral hygiene policy dated 2019 and staff had undertaken oral hygiene training to help ensure people received appropriate oral care.
• People had both health and oral hygiene passports which gave guidance to professionals about people's needs and preferences.
• A healthcare professional told us, "The staff all seem to know [person] well. [Staff] make sure they know about [person's] appointments in advance they are responsive to recommendations."

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. Care records showed that people had signed sections of these where they were able to give consent to their care. People's mental capacity had been assessed and best interests decisions had been made appropriately and as required.
• Where there were restrictions on people that could have amounted to a deprivation of liberty appropriate applications were made for DoLS authorisations. Any authorisations that were granted by the local authority were kept on record to evidence these and were part of the care planning so people received the care they needed.
• Staff completed training regarding the MCA and understood the principle of people making day to day decisions about their care.

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 good. At this inspection this key question has remained the same. 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
• During the inspection we observed an incident where a member of staff did not interact with a person in a very caring and respectful way. During an observed lunch we saw a person was being supported by this member of staff with their meal while they were sitting in an upright position. It was clear the person was unable to maintain this position independently and a member of the inspection team spoke with the nurse who positioned pillows behind the person's back which appeared to make them more comfortable. The original care worker showed little empathy with the person. For example, the person kept asking if they were doing the right thing, but the carer was more focussed on the task of the person finishing their meal than engaging with what the person was saying.
• However, we also observed positive staff interactions with people. For example, we saw someone who was restless. Staff brought a chair to sit beside them, stroked the person's hand and asked them about the soft toy they were holding. People said, "They are all nice to me here. I love it here", "I'm happy here they take good care of me" and "Staff sit and talk to you". Relatives commented, "[Person] calls here home and the fact they encourage [person] to be happy" and "It's always been a warm and caring place. Staff's warmth and affection have been phenomenal".
• Care plans recorded people's activities interests, social and cultural needs and provided staff with some guidance about how to support people in these areas. Staff were aware of people's diverse needs and how to support these, for example having some key words in a person's own language and supporting people to attend their place of worship.
• Maryville was run by a religious community and a number of people from that community were living in the home. A mass was held daily, which anyone could attend, and people from the religious community at Maryville maintained contact with other people outside the home but within their community.

Supporting people to express their views and be involved in making decisions about their care
• People were involved in day to day decisions about planning their care. People told us, "They come and get me up, they don't mind. I have prayers at seven o'clock", "I get up late as I go to bed very late. They don't make me get up fortunately" and "I get up very early. I get up at five. No one tells you what to do".
• People, and if appropriate, their relatives, were offered the opportunity to contribute to their review. They also had the opportunity to attend resident and relatives' meetings and feedback to the provider.

Respecting and promoting people's privacy, dignity and independence
• People told us staff respected their dignity and when providing personal care and one person said, "They always ask me before they do anything".

• People's independence was promoted and encouraged according to their abilities. We observed one staff member supporting a person to walk. They needed to pause to rest and staff were patient and encouraged the person by telling them they were doing well and nearly there.

Good

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 remained the same. This meant people's needs were met through good organisation and delivery.

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 were supported to maintain relationships and take part in activities. However, for people who were not very mobile or spent time in their rooms there were no clear records of how they were supported to take part in activities. The registered manager said that staff did spend time talking with people in their rooms daily and would in the future ensure that this was recorded in the daily notes. On some people's individual activity schedules watching tv was a staple. We did not see any activity in the home on the first day of the inspection and we were told this was because the person conducting the scheduled aromatherapy activity had taken someone to an appointment. On most days there appeared to be one organised activity which meant people might not always have the opportunity to engage in an activity that was meaningful to them.

We recommend the provider seek and implement national guidance on the provision of social and recreational activities that meet the needs of all people using the service according to their individual wishes and preferences.

• We saw evidence of group activities. Mass was available daily and on the second day of the inspection a choir came into the home. Activities in the home included choirs, parties, cinema, bingo and coffee mornings. We saw some good examples of activities that were personalised, including, one person who used to be a journalist, being taken by staff to a Christmas party in Fleet Street and another person who used to work for a department store was supported to attend their Christmas party.
• People were involved with others in the community including links with local schools and a memory café in the community which promoted interaction between people living in the home with the experience of dementia and those in the community. The home had also had a McMillian coffee morning to support people with cancer.
• Care records showed who visited people, and relatives told us they were made to feel welcome. One relative said on occasion they visited late at night and it was not a problem. Another relative said, "Family visits regularly. Our experience is very, very good. The staff are so helpful, understanding, cheerful and encouraging".

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• People's care plans were up to date and reflected their needs and the action staff should take to meet their identified needs. One relative said when they visited they were given an update by the registered manager "and that manifests itself when I see my [relative]" indicating staff were following the care plan.
• Care plans included people's routines and preferences, so for example, staff knew when people liked to get

up and their preferences for personal care.

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.
• We observed staff offer a person tea and the person could not hear them. Staff gently asked the person if they could check their hearing aid and adjusted it for the person so they could hear properly.
• Other staff spoke about using facial and body language to facilitate communication and being aware of key words in people's own language.

Improving care quality in response to complaints or concerns
• People and their relatives knew who to speak with if they wanted to raise a concern. A relative said, "I do have a copy of the complaints procedure. I have sometimes asked for an explanation of something an it is always forthcoming and always satisfactory."
• The provider had only had one complaint in the last two years and we found the registered manager had responded appropriately by investigating and acting in line with their complaints policy and procedure.

End of life care and support
• End of life wishes were recorded. At the time of the inspection, we spoke with a relative whose family member received palliative care in the home. They said, "The last years of [person's] life were secure safe and they were looked after in every possible way".
• The care plans we viewed had DNACPRs (Do not attempt Resuscitation Authorisations) and information about people's cultural and other needs. This meant people's wishes and particular preferences for care at the end of their lives were known in the event they required this support.

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 requires improvement. At this inspection this key question has improved to good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Continuous learning and improving care
At our last inspection we found the provider's quality assurance systems were not always effective. This was because they had not identified the areas of poor practice we had identified at the inspection, including not all PRN protocols were in place, inconsistent implementation of the Mental Capacity Act (2005), a lack of clear records to demonstrate that end of life care wishes were discussed and health and safety issues. This was a breach of Regulation 17 of the Health and social care Act 2008 (Regulated Activity) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

• The registered manager undertook a number of checks and audits that included the environment, health and safety, medicines, infection control and the managers completed daily safety walk around check lists. Care plans were last audited in July 2019 and included actions taken. The provider also had a service improvement plan that was updated monthly and recorded actions and outcomes for improving service delivery.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• People and their relatives were satisfied with the care provided.
• The registered manager promoted an open culture and was available to people using the service and staff. One person told us, "[The registered manager] is someone who listens."
• Staff found the registered manager approachable. One staff member told us, "[The registered manager and deputy manager] are very nice. They are open, and you can speak about anything with them. [The registered manager] comes on the floor and speaks with us and the residents. We are a big team."

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 responsibilities regarding duty of candour. They had policies and procedures in place and responded transparently when something went wrong, for example to complaints.
• People and their relatives knew who the registered manager was and felt there was good communication. People said, "She is very good, one of the nicest people I have ever met" and "I could talk to her if I wanted to. I see her wandering [around the home]". A relative noted, "[The registered manager] is very good, engaging a lot of the time. She runs a tight ship".

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.
• The registered manager kept up to date with good practice through newsletters from the local authority, CQC and their parent organisation. They also attended the local authority's provider forum. The deputy manager had completed the 'My home life leadership support programme' in March 2019 to develop their management skills in a care home setting.
• Although there had not been any since the last inspection, the registered manager was aware they needed to notify CQC 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.
• Staff told us they were confident raising concerns with the registered manager and that there was good communication within the staff team. Comments from staff included, "The management is good. Any problems, they are able to solve the issues" and "[The registered manager] is very good and supportive."

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.
• Team meetings were held to share information and give staff the opportunity to raise any issues. Staff who went the 'extra mile' to give care were recognised by their peers and given vouchers as the registered manager believed it was 'important to show recognition' to staff and promote teamwork.
• Relatives confirmed they had attended relatives' meetings and could raise concerns. We saw evidence of residents' meeting taking place. People and relatives also had the opportunity to put compliments on a tree in the reception area as a means of providing positive feedback to the provider.
• The provider asked people, relatives and staff to complete yearly surveys about their experience of the service and the feedback from the surveys was positive.

Working in partnership with others

• The provider worked with other health and social care professionals to assess and meet people's needs. These included the palliative care nurse, social workers and the GP.
• Families regularly visited and maintained good communication with the staff.