The Healthcare Management Trust

# Marie Louise House Nursing Home

**Inspection report**

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## Ratings

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|---|---|
| **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? | **Requires improvement** |
| Is the service well-led? | **Good** |

## Overall summary

This inspection took place on 30 November and 1 December 2015 and was unannounced.

Marie Louise House is a purpose built nursing home which opened in 2005. The home is owned by The Daughters of Wisdom, a religious order, and managed on their behalf by the Healthcare Management Trust and their board of Trustees. The Sisters from Abbey House convent work closely with the home providing pastoral support to the residents and their relatives. At the time of our inspection there were 45 people living at the home. The home is arranged over three floors. The Nightingale unit on the ground floor provides care for up to 10 people living with dementia some of whom were also physically frail and needed assistance with all aspects of their personal care and mobility. The Skylark and Kingfisher units provide general nursing care for up to 36 people.

Marie Louise House had a registered manager. A registered manager is a person who has registered with

# Summary of findings

the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager was new to the service having only been appointed in September 2015.

At our last full inspection in November 2014, we asked the provider to take action to ensure they were; acting in line with the principles of the Mental Capacity Act (MCA) 2005, providing person centred care and managing people's medicines safely. We found that staffing levels needed to improve and that the systems in place for assessing and monitoring the quality of the service also needed to improve. The provider sent us an action plan which described the actions they were going to take to make the required improvements. This inspection checked to see whether the required improvements had been made to ensure that the home was meeting these and other essential standards.

Improvements were being made which meant that there was an increasingly stable staff team available to meet people's needs. Whilst some staff felt that there could at times be insufficient staff, people told us their needs were usually met in a timely manner.

Action had been taken to ensure that, where people lacked the mental capacity to make decisions staff were more effectively applying the principles of the Mental Capacity Act 2005. This supported staff to act and make decisions in which were in the person's best interests.

The provider and new registered manager were taking action to strengthen the systems in place to identify, assess and manage risks relating to the safety of people and of the quality of the service. There was an increasingly robust quality assurance system in place.

People and their relatives were positive about the care and support they received. Staff knew people well and understood how to meet their individual needs in a person centred way. However, people's records did not consistently contain sufficient information about their needs and how these should be met.

The activities programme would benefit from further development to ensure its meets the needs of each person using the service including those living with dementia. We have made a recommendation regarding this.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were either in place or had been applied for.

Staff had received training in safeguarding adults and had a good understanding of the signs of abuse and neglect. Staff had clear guidance about what they must do if they suspected abuse was taking place.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. These measures helped to ensure that only suitable staff were employed to support people.

Staff had developed effective working relationships with a number of healthcare professionals to ensure that people received co-ordinated care, treatment and support.

People told us they were cared for by kind and caring staff who respected their choices, their privacy and dignity and encouraged them to retain their independence.

People were actively supported to maintain their religious and spiritual beliefs and this was fundamental to each person's wellbeing and the overall quality of their care. The home had close links with the Daughters of Wisdom living in the adjacent convent who provided pastoral support to people.

People told us they were able to raise any issues or concerns and felt these would be dealt with promptly.

Staff had an increasing confidence in the new registered manager to listen to their concerns and make improvements.. However, the relationship between some of the staff members was at times disharmonious and we were concerned that this could impact upon the care people received. The registered manager was aware of the need to work with the staff team to build relationships and a more productive culture and was already taking action to address this.

# Summary of findings

People and their relatives spoke positively about the registered manager and about the leadership of the home. The engagement and involvement of people and their relatives was encouraged, their feedback was being used to drive improvements.

# Summary of findings

## 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

Improvements had been to how people's medicines were managed.

There were enough staff to meet people's needs and the process used to recruit staff was robust and helped to ensure that staff were suitable for their role.

There were a range of systems and processes in place to help identify and manage risks to people's wellbeing. People were protected from risks associated with the environment.

**Good**

**Is the service effective?**
The service was effective

Staff had completed training in a range of subjects which helped to ensure they were able to perform their role effectively. Action was being taken to ensure that staff received regular supervision and had an annual appraisal.

Improvements had been made which met that the Mental Capacity Act was being consistently applied. There was evidence that consultation had been undertaken with relevant people such as GP's and relatives to ensure that the support plan being delivered was in the person's best interests.

People received a choice of meals and were supported appropriately to eat and drink and were supported to access healthcare services when needed.

**Good**

**Is the service caring?**
The service was caring.

People told us they were cared for by kind and caring staff and were treated with dignity and respect.

People were treated with dignity and respect.

People were actively supported to maintain their religious and spiritual beliefs. The home had close links with the Daughters of Wisdom living in the adjacent convent who provided pastoral support to people using the service.

**Good**

**Is the service responsive?**
The service was not always responsive.

People's records did not consistently contain sufficient information about their needs and how these should be met.

The activities programme would benefit from further development to ensure its meets the needs of each person using the service including those living with dementia. We have made a recommendation regarding this.

**Requires improvement**

# Summary of findings

Complaints policies and procedures were in place and information about the complaints policy was available in the service user guide. Complaints had been investigated appropriately.

**Is the service well-led?**

Good

The service was well led.

Staff had an increasing confidence in the new registered manager to listen to their concerns and make improvements. However, the relationship between some of the staff members was at times disharmonious and we were concerned that this could impact upon the care people received. The registered manager was aware of the need to work with the staff team to build relationships and a more productive culture and was already taking action to address this.

People and their relatives spoke positively about the registered manager and about the leadership of the home and the engagement and involvement of people and their relatives was encouraged and their feedback was being used to drive improvements.

# Marie Louise House Nursing Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection which took place over two days on 30 November 2015 and 1 December 2015. On the first day of our visit, the inspection team consisted of two inspectors, a specialist nurse advisor, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of service. Our expert had experience of caring for people living with dementia and of using health and social care services.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the registered manager tells us about important issues and events which have happened at the service. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with eleven people who used the service and four relatives. We also spent time observing aspects of the care and support being delivered. We spoke with the provider's Director of Clinical Services, the registered manager, the head of care, two registered nurses and eight care staff. We also spoke with the chef, the maintenance person and a member of the activities staff. We met with representatives of the Daughters of Wisdom the religious order that own the nursing home. We reviewed the care records of three people in detail and checked specific elements of the care records for a further six people. Our pharmacist reviewed the medicines administration records (MARs) of 32 people, the topical administration records of 3 people and 12 care plans to see what supporting information was maintained in relation to how people took their medicines. We also viewed other records relating to the management of the service such as audits, incidents, policies, meeting minutes, training and supervision records and staff rotas.

Following the inspection we sought feedback from three health and social care professionals and asked their views about the care provided at Marie Louise House Nursing Home.

The last full inspection of this was service was in November 2014 when we found concerns in relation to how the service was applying the principles of the Mental Capacity Act (MCA) 2005, providing person centred care and managing people's medicines. We also found that the staffing levels needed to improve and that the systems in place for assessing and monitoring the quality of the service were not sufficiently robust. The provider sent us an action plan which described the actions they were going to take to make the required improvements. This inspection checked to see whether the required improvements had been made and to ensure that the home was meeting these and other essential standards.

Good

# Is the service safe?

## Our findings

People told us they felt safe living at Marie Louise House. One person said, "Yes very safe, I would use the word secure, when I was ill, a hoist was used to get me from the bed to the chair, there was always two staff and they were brilliant". Another said, "If I didn't feel safe, I would talk to someone".

When we inspected in November 2014, we had concerns about how medicines were being managed within the service, This was because medicines were being over ordered and were not being stored safely. Medicines administration records (MARs) lacked supporting information for 'variable dose' or 'as required' medicines. Where medicines were being administered covertly, we unable to find evidence of mental capacity assessments for best interests consultations. Medicines were also not always being administered safely. At this inspection we found improvements had been made. Medicines were now being stored securely. The clinical rooms had been refurbished with the correct new equipment and storage facilities and air conditioning units had been installed. A new controlled drugs cupboard and lockable medicines refrigerators had been purchased. Controlled drugs are medicines that require a higher level of security in line with the requirements of the Misuse of Drugs Act 1971 as there can be a risk of the medicines being misused or diverted. The temperature of the refrigerators and rooms used for storing medicines were now being monitored daily. This provided assurance that medicines were being kept within their recommended temperature ranges. There were no longer concerns about medicines being over ordered. Arrangements were in place to ensure that unwanted medicines were disposed of safely. The service had agreed a list of homely remedies with each person's GP practice. Homely remedies are medicines the public can buy to treat minor illnesses like headaches and colds.

People's medicines were administered safely. People had an individual medicines administration record (MAR) which included their photograph, date of birth and information about any allergies they might have. The MARs we viewed contained no gaps or omissions, although we did note that the exact dose administered was not consistently recorded for medicines where the dose administered was variable. Following a medicines error we were able to see that the registered manager had acted promptly. A supervision session had taken place with the nurse involved along with a reassessment of their competency to administer medicines safely.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. The registered manager told us staff were reminded of their responsibilities with regards to keeping people safe and reporting any concerns at staff meetings and we saw that this was the case from minutes of these meetings. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Prospective staff were asked to think about safeguarding scenarios at their interview and we saw that both the permanent and agency staff hand book provided guidelines for dealing with suspicions or allegations of abuse. The registered manager demonstrated an open and positive attitude to reporting any concerns and to learning from these. The local safeguarding team had praised the registered manager for their prompt and detailed investigation following an adverse incident at the home. The investigation was very clearly documented and demonstrated a commitment to ensure measures were put in place to keep people safe and prevent similar incidents occurring. During our inspection, some information of concern was brought to our attention by staff. We shared this with the registered manager who took prompt action to investigate and address the concerns. Staff were mostly aware of the whistle-blowing procedures and were clear they could raise any concerns with the registered manager of the home. They were also aware of other organisations with which they could share concerns about poor practice or abuse.

At our last inspection in November 2014, we found that the provider had not ensured that there was always enough staff deployed to meet people's needs. At this inspection, we found that improvements had been made. Staffing levels had been increased since our last inspection. During the day the current target staffing levels were a registered nurse on each of the three floors. On the first and second floor the registered nurse was supported by four care workers and on the ground floor by two care workers. During night shifts there was again a nurse based on each floor with two care workers on the first and second floor and one on the ground floor. These target staffing levels were based upon the dependency needs of the people using the service and we were able to see that these had been assessed using a systematic approach. A number of

ancillary staff were employed also. For example, activities staff provided 72 hours of activities each week. The service also employed administration staff, laundry and housekeeping staff, a chef and kitchen assistants and maintenance staff. The provider and registered manager had worked hard to attract and recruit staff to their vacancies and in the last 12 weeks, 27 new staff had been employed. Whilst some of these staff were still getting to know the service and the people living within it, their recruitment had meant that the service had been able to reduce its use of agency staff. For example, no agency nurses had been required since September and reductions were also beginning to be seen in the use of agency care workers. Both people and staff told us this was a positive step forward. The staffing structure had also been amended. Each floor now had a unit manager who was responsible for overseeing the care of people and for managing the staff team effectively. The unit manager had supernumerary hours during which they could oversee the management of people's records and provide support and supervision to staff.

Most people felt that the staffing levels were adequate. One person said, "Yes they come quickly if I press my bell, sometimes, they come so quickly". A second person said, "Sometimes there is a little wait, but it's no problem I'm not going anywhere". One person did say that at times, if there was a lot of agency staff on duty, there could be a delay in their needs being met, they said, "There can be the right number, but some of them were are very inexperienced". A visitor told us, "On the whole there are enough staff, having a person in charge on each floor has helped". Our observations during the inspection indicated that people's needs were being met in a safe and responsive manner. Staff responded in a timely way to an emergency alarm that we accidentally triggered by standing on an alarm mat. Staff had mixed opinions about whether the staffing levels were adequate. Some felt that additional staff were still needed at times. However, most said there were usually enough staff to ensure that people received the care they needed and were for example, able to get up when they wanted to or have a bath. One staff member said there were enough staff "most of the time, yes its getting better, I'm optimistic". Others felt there was still room for improvement. A number of staff expressed a wish that there was better team work with the nursing staff. They felt that this along with the ongoing reduction in agency staff would ensure that the staff levels remained appropriate.

Appropriate recruitment checks took place before staff started working at the home. The registered manager had obtained references from previous employers and checked with the Disclosure and Barring Service (DBS) to ensure the staff member had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post. Checks were made to ensure the registered nurses were registered with the body responsible for the regulation of health care professionals.

People's records contained appropriate risk assessments which covered a range of areas. For example, clear moving and handling risk assessments were in place which contained detailed and specific guidance to support staff to move people in a safe and effective manner. Where people were at risk of pressure ulcers, relevant risk assessments had taken place and were reviewed monthly. Screening for the risk of malnutrition was routinely carried out and people's weight was regularly monitored. Care workers told us that the risk assessments informed them what they needed to know about each person and how to deliver their care safely. We did identify that risks associated with swallowing difficulties and choking had not always been fully assessed and planned for. For example, the care plan of one person noted that they were at risk of aspiration due to swallowing difficulties; it said that staff should monitor for signs of aspiration, but did not say what these were. We raised this with the registered manager and head of care who took immediate action to update the person's records to ensure they contained care plans and risk assessments with regards to choking and how this should be managed. The following day a briefing was held with all staff to ensure they were informed about best practice guidance in relation to providing first aid to people who might be experiencing an episode of choking.

There were a range of systems and processes in place to identify and manage risks to people's wellbeing. Incident and accidents are all monitored by the registered manager and we were able to see that they maintained a record of the actions taken in response to mitigate any risks and prevent reoccurrences. Handover meetings were conducted daily during which staff shared information about any new risks or concerns about a person's health.

Good

# Is the service safe?

Further developments were also being introduced which would help to effectively manage risks within the service. For example, an electronic care planning system was being introduced. This allowed staff to use electronic devices to access and record information about a person's needs and risks and how these were being managed. For example, if a staff member recorded that a person had a fall, it required the staff member to record what actions had been taken in response. Where two care workers were required to undertake manual handling procedures, both staff had to each log in to the system to confirm that they were involved and completed the intervention safely.

People were protected from risks associated with the environment. Each person had a personal emergency evacuation plan which detailed the assistance they would require for safe evacuation of the home. The fire risk assessment and fire equipment tests were up to date and staff were trained in fire safety. The provider also had a business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service. Weekly checks were undertaken of the safety of aspects of the environment such as the window restrictors and monthly checks were undertaken of the water system to ensure the effective control of legionella.

Good

# Is the service effective?

## Our findings

People and their relatives told us the service provided effective care. One relative said, "The permanent staff seem well trained". They told us how staff had helped their relative to improve since they had come to live at the home. Another relative said, "[the staff] are really switched on to the needs of older people and they meet these consistently". A person said "There is lots of good quality care around here, I am very happy, I have a lovely room". Another said "The care is excellent, cleanliness marvellous, I would definitely recommend it".

Staff had completed training in a range of subjects such as infection control, Mental Capacity Act (MCA) 2005, fire safety, safeguarding, health and safety, dementia care, equality and diversity, food safety and manual handling training. Where relevant to their role, some staff had completed additional training such as the safe handling of medicines and caring for wounds. Records we viewed showed that this training was generally up to date. The registered manager said there were plans to provide additional training on report writing and communication. They explained that they wanted this to be provided face to face and so were trying to source this at present. The service had supported a number of staff to enrol on nationally recognised health and social care qualifications at a local college. These were in subjects such as team leading, management, nutrition and diabetes. One staff member was taking a course to support them in their role of being infection control lead for the service. All of the staff we spoke with said that the training provided was adequate to enable them to perform their role effectively. The health and social care professionals who visit the service told us the staff team were suitably skilled to meet people's needs. One said "The staff are knowledgeable and informed about people's needs, most have a good understand of medication and the side effects, there is a good understanding of mental capacity and safeguarding". Another social care professional told us, "The care staff always seem keen to learn and to keep up with good practice in manual handling".

Staff were not currently receiving supervision in line with the frequency as determined by the provider. Supervision and appraisals are important as it helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. The provider's policy said this should be provided every eight weeks. The new registered manager was aware that improvements were needed and they were beginning to roll out a programme of appraisals and supervision, however, these improvements will need to be embedded in practice and sustained. Most of the staff we spoke with felt increasingly supported in their role. For example, "One staff member said, "Last week, I mentioned something at a staff meeting and was given clear instructions about what course of action to taken in the future". Another staff member said, "The head of care and manager are very supportive". The registered manager explained that to support staff further, the staffing structure had been reviewed as staff had felt this was not working. They had introduced 'mentors' who were senior staff who had done mentorship training which included learning about how to give feedback and to share their skills and knowledge. Staff told us this structure was better and proving to be more nurturing and supportive.

New staff completed an induction during which staff learnt about their role and responsibilities and undertook some essential training. They also spent time shadowing the more experienced staff and reading people's care plans which helped to ensure that they were able to develop their understanding of people's needs. The induction was mapped to the Care Certificate which was introduced in April 2015. The care certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate and should ideally be completed within the first 12 weeks of employment.

At our last inspection in November 2014, we found that mental capacity assessments had not always been carried out in line with the Mental Capacity Act (MCA) 2005. We issued a requirement. 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. At this inspection, we found that improvements had been made.

Some people living at the home were not able to give consent to some aspects of their care and treatment. Where this was the case the records we viewed contained

Good

# Is the service effective?

mental capacity assessments. Where people were deemed to lack capacity, there was evidence that consultation had been undertaken with relevant people such as GP's and relatives to ensure that the support plan being delivered was in the person's best interests. We did note that some people had care plan consent forms signed by relatives without there being evidence that the relative had legal authority to do so. Staff had a good knowledge of the MCA 2005 and what it might mean for the people in their care. One care worker said, "People have a legal right to make their own decisions about things that affect them for as long as they are able. We have to remember to assume that people have capacity unless there is proof to the contrary. Where people had capacity to consent, staff sought their consent before providing care and support and respected their choices. We saw or heard staff asking people whether they would like to get up, what they would like to eat and drink and whether they would like to join in activities. A person told us, "If I didn't want the care at the time, I would say so and they would come back". Staff were seen to respect people's decisions and choice and were able to describe how they tried to support and empower people to make decisions for themselves. A staff member told us, "I hold their hand, say who I am, say what I am there for, they squeeze my hand, I don't rush them, I give them time to answer".

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. The registered manager had a good understanding of what might constitute a deprivation of a person's liberty and relevant applications for a DoLS had been submitted by the home and they were waiting for these to be assessed by the local authority.

Most people told us they enjoyed the food provided. One person told us, "I like the dining room, we're a chatty lot, I find someone to talk to, I get plenty of fruit every day, they are good at that, the food is lovely". Another said, "Lunch is fun, I talk to friends". A third said, "The food is tasty and what I want more or less, I like everything. I go down for my meal and enjoy it. If I wanted a snack, I would get one. There is always fresh fruit available for me and plenty of drinks". On the day of our inspection, people could choose between a fillet of sea bass or a minted lamb burger, but alternatives were available. A person told us, "I can have a jacket potato if I don't like anything else". Another told us that as they did not eat meat, the chef made them cauliflower cheese or fish which they loved. We saw that breakfasts were also tailored to suit people's individuals needs with cereals, yoghurt or a cooked breakfast being offered. At lunch, meals were either served in the dining room, or taken in a hot trolley to each floor to be delivered to people who preferred to eat in their own rooms. Kitchen staff had detailed information about people's specialist diets including those that required diabetic meals and those that needed soft or pureed food. We did note that further work could be done to enhance the eating and drinking care plans of people living with diabetes to ensure these provided an individualised nutrition plan.

We observed the lunch time meal on the first day of our inspection which appeared overall to be a pleasurable and dignified experience for each person. There was a pleasant atmosphere and music was playing in the background. Where necessary people were provided with adapted crockery which helped them to maintain their independence and dignity. We did on one occasion observe staff supporting two people to eat at once and another staff member standing when helping a person cared for in bed to eat and drink. We raised this with the registered manager who told us that all staff would be reminded of the importance of supporting people to eat in a manner that was person centred.

Where necessary a range of healthcare professionals including GP's, community mental health nurses, dentists and speech and language therapists, had been involved in planning people's support. This helped to ensure that they received co-ordinated care, treatment and support. Each week, a GP made a routine visit to the home during which they were able to review people about whom staff had concerns or who were presenting as being unwell. The effectiveness of medicines were appropriately monitored to ensure that people's day to day health needs were met. We reviewed the records of six people who were prescribed medicines that required regular monitoring. Their test results, and recommended doses were recorded and subsequent tests scheduled. Signs and symptoms of over and under treatment and supporting actions including summoning expert advice were recorded in their care plans. People were supported to maintain or retain good health. For example, we saw that one person who had

Good

# Is the service effective?

come to the home for end of life care was now leading an independent and fulfilled life. A health care professional told us, “The standard of nursing care is excellent, as is the standard of hygiene and care with feeding and nutrition”.

Good

# Is the service caring?

## Our findings

People told us they were cared for by kind and caring staff. One person said, "I am very happy, very lucky, very fortunate, the staff are all kind and caring, very gentle, very nice, I would recommend the home, I think they would be very happy". One relative said, "Staff are very kind and caring, sensitive as well". Another relative said, "I have no criticisms about this home, I come in every day at different times and so do the family, If there was something wrong we would know. All the carers and nurse here are brilliant; they cannot do enough for you". A social care professional said, "The staff are kind, caring and nurturing to the people they care for and they show great patience, encouragement and positivity".

Our observations indicated that staff interacted with people in a kind and compassionate manner and we saw a considerable number of warm and friendly exchanges between staff and people. For example, we saw one care worker gently stroking one person's face, trying to rouse them for lunch; the lady opened her eyes and smiled. Staff made eye contact with people when speaking with them and chatted positively whilst completing care tasks. The atmosphere in the communal areas was good natured and sociable.

There was some evidence that people were involved in planning their care. For example, we saw that some people had signed a form to confirm their agreement to their care plan, however in many cases this was signed by a relative. Whilst we saw that care plans were evaluated each month, it was not evident that this was with the involvement of the person or their relatives and this could be better documented. Overall though people said that they were satisfied that they were able to express their views and that these would be listened to. Relatives told us they were usually kept well informed and that communication with the home was good. One relative said, "I have had long talks with [the head of care] and filled in umpteen forms, I am involved in decisions".

Staff told us how they supported people to maintain their independence by encouraging them to complete small tasks such as brushing their teeth or walking to the bathroom. People were not put at unnecessary risk but were, where able, supported to remain in control of decisions about how aspects of their care was managed despite the potential risks this might involve. For example, staff told us how one person valued being able to walk independently. To address the risks involved in this, 'rest chairs' had been placed at intervals which enabled the person to still walk but also take regular rests. Another person who normally only had a soft diet really enjoyed salads and so after a full discussion around the risks, it was agreed with them that occasionally they would have a salad but that a member of staff would sit with them whilst they ate. We also saw that a number of people were being supported to continue to administer their own medicines and that systems were in place to support this so that people retained control over their own medicines. One person told us "I go for a walk every morning. It's fine so long as I tell them where I'm going and I take my mobile – fully charged".

People's relatives and friends were able to visit without restrictions, and we observed relatives visiting throughout the day and sharing in aspects of their loved ones care. One relative told us, "The welcome you get is lovely from all the staff".

People were treated with dignity and respect. One visitor said, "The staff are very respectful, there is a lovely rapport between staff and residents" A person said, "They are very mindful of my privacy when giving me a bath". Another said, "We're a team, they respect me and my privacy". The questionnaire completed by people in October 2015 showed that all of the respondents felt that the respectfulness of staff towards them was either good or outstanding. Staff told us how they knocked on people's doors before entering, or placed a towel across the person's lap when assisting them with personal care. The manager told us that any prospective staff were asked about their values and asked to talk about scenarios which made them think about people's dignity at their interview. They said it was important that they employed staff who understood how to protect people's dignity. They also explained that they had plans to encourage relatives to become dignity champions to support best practice. A health care professional told us, "They greet people by name, explain what they are going to do…have closed doors with a sign when carrying out personal care". Another said, "From what I have observed, the residents are treated with great dignity and respect".

People were actively supported to maintain their religious and spiritual beliefs. The home had close links with the Daughters of Wisdom living in the adjacent convent who

Good

# Is the service caring?

provided pastoral support to people using the service. The registered manager was developing links with other local church leaders to further enhance the pastoral support offered and we saw that efforts had also been made to recruit staff of other non-Christian faiths so that the staff team were supported to have a better understanding of the various cultural needs of the people they cared for. It also helped people who used the service to follow their individual religious and cultural practices.

Requires improvement

# Is the service responsive?

## Our findings

At our last inspection in November 2014, we found the planning and delivery of care had not always been person centred. At this inspection, we found some improvements had been made. People's individual care plans were more organised and better structured. Most contained guidance and information for staff within them was suitably detailed and comprehensive. For example, we looked at six moving and handling care plans and found that they contained completed and up to date information about how the person should be moved safely and being mindful of their comfort. However, we found that a small number of care plans could contain more detailed information about specific aspects of people's needs or how these should be met. For example, three people's care plans did not record the type of dementia the person was living with or contained conflicting information about this. This information is important as the different types of dementia progress in different ways and can result in people having differing care and support needs. We saw that some people's behaviour support plans did not always provide comprehensive information about how staff should manage incidents of behaviour which might challenge others. There were no skin care plans or wound care plans for one person who had recently been successfully treated for skin damage. Some of the records relating to how the service managed people's medicines could be improved. For example, whilst some information was available for "variable dose" or "if required" medicines, this did not always provide sufficient personalised guidance for staff about when these should be given. For example, we looked at the care plans for four people who could display behaviour which challenged other or had 'just in case' medicines to manage spasms. These lacked details about how and when these should be used. One person's care records contained information about the suitability of the medicines for administering with food. However since the information had been provided, the medicines had changed, but updated pharmacist advice had not been obtained. Staff completed topical medicines administration records (TMARS), but these did not include details of where the creams should be applied. This could impact on people receiving their creams as prescribed. The registered manager told us that immediate action would be taken to update TMARS to include this information.

Whilst aspects of people's care records could be improved, people told us that staff had a good understanding of their needs and of their preferences in terms of how their care was provided. One person said, "Yes I can talk with them [the staff]. On the whole they're very good and they know me yes". Another said, "They know how I like things". Relatives also felt that their loved ones mostly received responsive and attentive care, one said, "My parent needs nursing now, they have to rely on [the staff] and anything my parent asks the staff will do…they know her and my parent is happy. If my parent asked for something not to happen just then, the staff adjust…they are well aware of my parents health needs". Another relative said, "The staff are so good, they know people". A healthcare professional told us, "[the staff] are well informed about people's needs and their support plans and I feel able to confidently rely upon accurate information about people's needs".

People and their relatives felt that staff recognised and responded to changes in their health care needs. A visitor said, "They [the staff] anticipate people's needs, the nurses seem to be more constant, they know my wife's needs….they let me know if she is unwell". A person told us, "They are good at getting the doctor, sometimes, they go over the top!"

We were able to see that staff made referrals in a timely manner to healthcare professionals. For example, one person had been referred to the falls clinic following a fall. Another person had been referred for a review by the community mental health team following a decline in their mood. It was evident that staff were recognising that people were increasingly confused or showing signs which might indicate that they had an infection. We were able to see that the GP was contacted to review these people so that appropriate treatment could be commenced.

Throughout the inspection, we observed that staff were attentive to people's needs and offered regular assistance and support. For example, we saw that one person had left their tea and this had gone cold. A carer noticed this and fetched a replacement and then sat with the person chatting with them until they had finished all of their drink. This was a skilful and attentive way to encourage the person to drink. During lunch time, a person asked to go to the toilet, they only had to wait a moment before staff assisted them. Staff regularly checked on people and supported them with care tasks throughout the day in a calm and unrushed manner.

Requires improvement

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We looked at people's records to check that their wishes and preferences were taken into consideration when planning their care. People's care plans currently contained a 'This is Me' document and a 'Daily Routine' record which provided some information about the person's preferred daily routines and their likes and dislikes. The kitchen also had a list of people's catering preferences. However the level of information within these was variable. The registered manager explained that there were plans to work with people and their families to introduce a 'My Life' document which was a more comprehensive record of the person's family, life, hobbies and interests, information about their needs, how they communicated or things that worried them. Staff told us that additional information about people's lives would be useful and would help them to understand people and talk to them about things that were important to them.

The activities programme would benefit from further development to ensure its meets the needs of each person using the service. A range of activities were provided. The service employed three activity coordinators who provided a range of both group and one to one activities on week days for people living at the home. A schedule of activities was advertised and included cooking, quizzes, visits from outside entertainers and visits by animals such as tawny owls and a greyhound. There had recently been an afternoon of remote controlled car races. Some exercise based activities also took place, although a number of people did tell us that they would like more activities of this nature and more opportunities to enjoy the grounds and take walks in the gardens. We saw that the activities staff spent time engaging people in conversations about current affairs by reviewing the newspapers. Board games and sing songs were also held. The home had a mini bus and had recently recruited a mini bus driver to facilitate trips out to town or to local places of interest. The week prior to our inspection people had enjoyed trips out to Hythe, A local garden centre and the local library. We did note that at weekends, the only planned activity was a film showing in the communal lounge. We also felt that many of the activities offered could be more tailored to specific needs of people living with dementia. 13% of those that responded to the residents and relatives questionnaire felt that the activities offered were adequate, 4% felt they were inadequate.

**We recommend that the service consider best practice guidance on the provision of meaningful and stimulating activities for people living with dementia.**

Records were kept of the activities that people took part and these showed that people cared for in their rooms received a visit from the activities staff two or three times a week who listened to music with them, provided a massage or just had a chat. People generally felt the activities provided were adequate. Comments included, "Sometimes there's something on, activities, entertainment, it's rather nice, I like that". Another person said, "I will do the cooking, but its not that often, tomorrow a greyhound and its owner is coming in, I will enjoy that". A relative said, "They massage cream into my parent's arms and hands, one to one it's very good, they are encouraged to do activities. There is lots of entertainment" Another relative said, "Activities are one of the things the home does really well, I join in myself!"

Complaints policies and procedures were in place and information about the complaints policy was available in the service user guide. People and relatives were mostly confident they could raise concerns or complaints and these would be dealt with. One person said, "I only have niggly complaints, they listen". Another said, I've never had a complaint, but if I did I would see the first one around". The complaints records showed that there had been no complaints since August, those made earlier in the year had been fully investigated in line with the provider's policy.

Good

# Is the service well-led?

## Our findings

At our inspections in June and November 2014, we found that the service was in breach of the regulation that relates to good governance. This was because it did not have effective systems in place to assess and monitor the quality of the service. We issued a requirement. At this inspection we found improvements were being made and embedded in practice. The provider had been open with people and their relatives about the concerns we had found during our last inspection. They had arranged for a team which included their Director of Clinical Operations and Audit and their Compliance manager to spend considerable time at the service supporting the staff team and driving improvements. They had overseen a recruitment drive; including the appointment of a new manager, and the provision of additional training. People and their relatives felt that this had resulted in improvements. A person told us, "They have been short staffed, but not now". One visitor said, "Everything has improved, there is a happy atmosphere, everyone seems content". A health care professional told us, "The home now has good management; this makes a huge difference to the running of the service".

A range of audits were being undertaken to monitor the effectiveness of aspects of the service including care documentation, call bell response times, infection control and medicines management. Where areas requiring improvement were identified, a clear action plan had been drafted which included who would be responsible for ensuring improvements were completed. The registered manager told us, "We audit to see how we can improve, we do see where our faults are, we are striving to do better". Each day the registered manager undertook a 'round' of the home which helped to ensure she kept abreast of issues affecting people's care and the staff team. This also helped to ensure that they maintained visible leadership. The unit managers submitted a weekly report to the registered manager which looked at issues such as number of agency staff that had been required, staff sickness, falls, complaints, medicines errors and pressure ulcers. There was evidence that the registered manager had reviewed these weekly reports and provided feedback to staff about any further actions' that might be necessary. The registered manager also prepared a weekly and monthly report for the provider about risks within the service and how these were being managed. This included for example, an analysis of all incidents and accidents, the outcome of audits and compliance with clinical alerts or NHS patient safety alerts. The registered manager told us that this helped to monitor issues that could affect the safety of the service. Throughout the inspection, where we identified areas of the service that could improve, the registered manager took prompt action to address these.

People and their relatives spoke positively about the new registered manager and about the leadership of the home. Comments included, "The new manager is lovely, very approachable, she sees more of us than any of the others, she comes and see you and smiles" and "[the manager] comes round the lounges and talks to people individually". A relative said, "I am very happy with [the registered manager]". A health care professional told us "The service seems to be well led and managed".

The engagement and involvement of people and their relatives was encouraged and their feedback was being used to drive improvements. Meetings with people and their families took place regularly. We saw the minutes of these meetings. They had been well attended and were used as an opportunity for people to make suggestions about how the service could be improved. For example, we saw that people had suggested activities they would like to take part in. This had been acted upon. One person said, "[the registered manager] is very approachable, you can suggest things". A satisfaction survey had recently been undertaken with people. The responses were being formulated into an action plan so that any areas for improvement could be addressed. Overall, however, the feedback indicated that people's satisfaction with the service and the care they received had improved since the previous year. Comments included, "Since the arrival of the new home manager, things are definitely on the up and a much better atmosphere prevails".

Morale amongst the staff group was variable. Some staff told us that they were very happy working at Marie Louise House. They felt valued, listened too and supported. One staff member said, "The manager comes round every morning, [the head of care] is always there too, they always have their door open". Another care worker said, "Its early days, but [the registered manager] is getting things done". A third care worker said, "Things are slowly improving, I do feel the manager is driving improvements". Other staff however, continued to feel demoralised and told us that the staff team did not always work well together. A number

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of staff spoke to us of conflict or disharmony amongst the staff team. These views were broadly supported by the result of the staff survey which showed that 29% of the staff that responded felt morale and teamwork was not good. We spoke with the registered manager about this. They were aware of the need to work with some members of the staff team to build relationships and a more productive culture and they were already beginning to address this through supervisions with team members and through reviewing unit assignments and staff shifts. They told us that it was important that staff felt valued and that to support this, the provider had introduced a number of incentives such as a staff rewards scheme and staff nights out.

The registered manager told us that central to the philosophy of care of the service was the commitment to the Christian values of the Daughters of Wisdom and the importance of providing care with dedication and compassion. Our observations and conversations with people indicated that they did feel safe and secure at Marie Louise House and were cared for by staff who were attentive to their needs and treated them with kindness and compassion. This was echoed by a healthcare professional who told us, "I go into a number of homes and feel the atmosphere at Marie Louise House is amongst the best, they try to ensure that all basic needs are met and often go that extra mile".

Whilst it was early days, the manager was beginning to develop a vision for the future of the service underpinned by the aim to achieve ongoing improvement and the provision of person centred care. Plans included developing the end of life care provided within the home, considering whether the environment could be made more for people living with dementia, enhancing the activities programme and stabilising the staff team. They had made arrangements with the vicar of Romsey Abbey to begin visiting the home and host discussions about end of life care and living with dementia. They planned to develop links with local community dementia champions. They were facilitating Parkinson Community meetings at the home from the new year with the Parkinson's nurse, resident and relative representatives and matrons from other homes. The registered manager knew there was still more to be done and demonstrated a good understanding of the challenges her role presented. The registered manager told us that they were well supported by the provider. We saw that the trustees had recently made an unannounced visit to the home and met with staff and people using the service. They had produced a report of their findings which were largely positive. The Daughters of Wisdom were also regular visitors to the home and took opportunities to speak with people and staff and the quality of care they received to provide pastoral care.