The Healthcare Management Trust

Marie Louise House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service responsive?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 24 and 25 November 2014. Breaches of legal requirements were found and we issued a warning notice for a breach in relation to the maintenance of proper records. The provider was required to meet the regulation by 16 February 2015.

As a result we undertook an unannounced focused inspection on 10 April 2015 to follow up on whether action had been taken to meet the requirements of the warning notice. You can read a summary of our findings from both of these inspections below.

Comprehensive inspection of 24 and 25 November 2014.

This inspection took place on 24 and 25 November 2014 and was unannounced. At the last inspection in June 2014, we asked the provider to take action in relation to how people consented to their care and treatment, the care and welfare of people, how workers were supported, how the safety and quality of the service was monitored and the maintenance of records. The provider sent us an action plan which described the actions they were going to take to make the required improvements. Whilst at this inspection, we found some improvements had been made; further action was required to ensure that the home was meeting these and other essential standards.

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. 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.

Summary of findings

Marie Louise House has not had a registered manager since June 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A new manager was appointed in October 2014. They plan to make an application to be appointed the registered manager, although this has not yet been submitted.

Staffing levels required improvement. People told us that they had to wait for support and assistance. Target staffing levels were not always met and agency staff were required on a regular basis which meant staff struggled to meet people's needs in a consistent manner.

The management of medicines required improvement. Records contained insufficient information to ensure the consistent administration of medicines to people. Medicines were not always administered safely.

Mental capacity assessments were not being undertaken with due regard to the MCA 2005. When a person lacked capacity to make decisions about their care, we were not always able to see that appropriate best interests consultations had been undertaken.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The manager had submitted an application for one person's DoLS appropriately. However, they were not fully aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. There was a risk therefore that some people might have their liberty or choices restricted without the proper authorisations being in place.

People's wishes and choices were not always listened to. Improvements were needed to ensure that all staff understood how to respond and interact with people in a manner that demonstrated to the person that they mattered and that their wishes and choices are valued.

People did not always have a detailed plan of care which ensured staff could meet their needs. People were not always receiving care in line with their care plan and people did not always receive care when they needed it.

People's records did not always contain enough information about their needs to ensure that staff were able to deliver responsive care. Some records were not completed accurately.

Improvements were needed in relation to how the provider and manager identified, assessed and managed risks relating to the safety of people and of the quality of the service. We identified concerns in a number of areas including medicines management, the suitability and accuracy of records and staffing levels which showed that there was a lack of robust quality assurance systems in place.

Despite our findings people did however tell us they felt safe living at Marie Louise House. Most staff had received training in safeguarding adults and had a good understanding of the signs of abuse and neglect and were aware of what to do if they suspected abuse was taking place.

Safe recruitment practices were followed which made sure that only suitable staff were employed to care for people in the home.

Most people told us that they received effective care from staff who had the skills to support them. Some staff had not completed all of the training relevant to their role. However staff seemed to have a good understanding of their role and responsibilities.

There was an effective working relationship with a number of health care professionals to ensure that people received co-ordinated care, treatment and support including memory nurses supporting those living with dementia and respiratory nurses working alongside those with breathing difficulties.

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 knew how to make a complaint and information about the complaints procedure was displayed within the home and included in the service user guide, including how to raise concerns with the Care Quality Commission.

People said they had no concerns about the leadership of the home. We found that the manager was still getting to

Summary of findings

know the home, the people living there and the staff, but was also actively working to develop their understanding of what the home did well and the areas it needed to improve on.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which now corresponds to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Focused inspection 10 April 2015.

At our inspection in November 2014, the provider was issued with a warning notice as they had failed to ensure they maintained an accurate record of the care and treatment received by each person. The provider was required to meet the regulation by 16 February 2015.

As a result we undertook an unannounced focused inspection on 10 April 2015 to check whether action had been taken to meet the requirements of the warning notice.

We found that the provider had taken sufficient action to meet the requirements of the warning notice. Overall we found that people's care plans were more detailed and were being reviewed regularly. It was evident the provider was taking action to personalise and improve the level of detail contained within people's care plans. People's care and monitoring records were being more consistently maintained and more accurately reflected the care and support they received.

We did find that some people's care plans could be improved still further, for example, two of the diabetic care plans we viewed required additional information to ensure staff were able to provide an appropriate response should the person experience low blood sugar levels as well as high blood sugar levels. One person's pain plan did not include details of the signs or behaviours which might indicate that they were in pain. Since the inspection, the provider has sent us updated care plans which address these omissions.

Measures had been put in place to drive on-going improvements of the records of people's care and treatment. The provider had arranged for the home to have additional support from its Director of Clinical Operations, Audit and Compliance Manager and managers from other homes run by the provider. Detailed audits were being undertaken of each care plan and these highlighted clearly where improvements were still needed. Staff had received training in care planning to enhance their skills and knowledge and they were being encouraged to take accountability for, and to be part of, the work underway to improve people's records.

We will undertake another unannounced inspection to check on all other outstanding legal breaches identified for this home.

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 responsive?

Requires improvement 

Comprehensive inspection 24 and 25 November 2014.

The service was not always responsive.

The home was not organised in such a way as to ensure staff could always be responsive to people's needs and choices and provide their care in a personalised manner. People did not always receive their care when they needed it.

People's records did not always contain enough information about their needs to ensure that staff were able to deliver responsive care. Some records were not completed accurately.

People knew how to make a complaint and information about the complaints procedure was displayed within the home and included in the service user guide. Complaints were fully investigated and action was taken to address the concern.

Focused inspection 10 April 2015.

People's care plans were more detailed and were being reviewed regularly. People's care and monitoring records were being more consistently maintained and more accurately reflected the care and support they received.

Marie Louise House Nursing Home

Detailed findings

Background to this inspection

This inspection report includes the findings of two inspections of Marie Louise House Nursing Home.

We carried out these inspections 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 first, a comprehensive inspection of all aspects of the service, was undertaken on 24 and 25 November 2014 and was unannounced. This inspection identified breaches of regulations.

The second inspection was undertaken on 10 April 2015 and focused on following up on actions taken in relation to the breach of one of the legal requirements we found on the 24 and 25 November 2014.

You can find full information about our findings in the detailed findings sections of this report.

Comprehensive inspection 24 and 25 November 2014.

The inspection team consisted of two inspectors, a pharmacy inspector, a specialist nurse advisor in the care of frail older people living with dementia, 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 service. Our expert had experience of supporting 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. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

We spoke with 13 people who used the service and three relatives. We also spoke with the manager, head of care, assistant chef, two registered nurses, six care workers and an activities co-ordinator. We reviewed the care records of ten people in detail and the records of four staff. We also reviewed the Medicines Administration Record (MAR) for 28 people, the medicines sections within care plans for five people and Topical Medicine Administration Records (TMAR) for three people using the service. Other records relating to the management of the service such as training records and policies and procedures were also viewed.

Following the inspection we contacted two community health and social care professionals who shared their views on the home and the quality of care people received.

The last inspection of this service was in June 2014 when concerns were identified in a number of areas. We found that mental capacity assessments were not always being carried out in line with the Mental Capacity. Staff did not have all of the training relevant to their role and had not been receiving regular supervision. Care plans did not provide sufficient detail about keys risks to people's health

Detailed findings

and welfare and care was not always being delivered in line with people's care plans. Audits were not being effective at driving improvements and some records had not been fully completed which meant that the service was not always maintaining an accurate record of the care and treatment each person received.

Focused inspection 10 April 2015.

This inspection was carried out by an inspector. 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.

We spoke with two people who used the service. We also spoke with the manager, Director of Clinical Operations; a Matron Manager from another of the provider's homes and two other staff members. We reviewed the care plans of seven people in detail and the daily records of a further eight people.

Requires improvement

Is the service responsive?

Our findings

Comprehensive inspection 24 and 25 November 2014.

People's views about how responsive the service was were mixed. Some people told us staff were responsive to their needs. However, three people told us they did not always receive care when they needed or wanted it. One person told us, "When I want my pad changing there have to be two members of staff who are appropriately qualified to take me. I have to wait and it can be uncomfortable, especially in the morning". We observed that at 11am a staff member told this person they would be available to assist her soon. They did not return until 15 minutes later. Call bell audits showed that each day, a number of people waited between five and ten minutes for their call bell to be answered. For example, on the 19 November 2014, there were seven occasions when people were waiting in excess of six minutes. One person waited 14 minutes. Similar figures were recorded on each of the days viewed.

When we inspected in June 2014, some people's records had not been fully completed or contained gaps and omissions. At this inspection, we found that the provider had not made the required improvements. Seven of the ten care plans we reviewed did not provide sufficient information about key risks to people's health and welfare because they contained out-of-date, inconsistent or incomplete information. For example, one person's diabetic care plan did not contain sufficient detail about how staff should respond in the event of their blood sugar readings being too high or too low. There was no further guidance about how staff might try to anticipate this person's needs. Two people's care records contained falls risk assessments and falls care plans. However these had not been updated or reviewed following a fall. Ensuring that care plans contain adequate guidance about people's needs is important so that staff understand how to support the person effectively. Communication care plans did not always demonstrate a good understanding of the needs of people living with dementia. Dementia can be characterised by a loss of ability to communicate and it is important that staff understand what each person means by the various expressions and behaviours they use. The communication care plans we saw did not provide adequate guidance for staff.

The continence care plan for one person stated 'To ensure comfort, change pads four hourly or as needed'. On the 7, 8 and 9 November, records suggested that this person's pad was only changed twice throughout the 24 hour period. This was also the case on the 22 and 23 November 2014. A care worker told us, "It must be record keeping as people have their pads changed when they need it". Another care worker said, "It's probably that staff are busy and just forget to write it down". This meant that the home had not ensured that each person had an accurate record of the care and treatment they receive. Maintaining accurate records of the care and treatment people receive is important as these records help staff to monitor and evaluate the effectiveness of the care plan in meeting people's needs. From this we could not be assured that appropriate support had been given.

People's care plans were being reviewed monthly and changes were recorded on an evaluation sheet stored alongside the main care plan. However the care plans were not being amended to reflect any updated guidance on how to deliver the person's care. We were concerned that staff would have to read the care plan and all of the monthly evaluations to be confident they had all of the relevant information about the person's needs. This could lead to confusion as to people's current needs and the level of support they required.

People's records did not always contain enough information about their needs to ensure that staff were able to deliver responsive care. Some records were not completed accurately. Further improvements are needed to ensure that each person receives care, treatment and support which is responsive to their individual needs. This is a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

There were some examples of action being taken in response to changes in people's needs. For example, one person was noted to have lost weight in October 2014. We saw evidence that they were referred to their GP who started them on food supplements. This person's weight was checked more frequently and by November 2014, we noted that there had been a slight weight gain. Another person had a short term plan in place to treat and manage the symptoms of a chest infection. A third person was noted to have gained weight; this was an identified risk to this person's health. In response the person was referred to a relevant healthcare professional for a full review.

We received mixed feedback about the activities programme offered by the home. One person told us, "I

Is the service responsive?

can't go anywhere, or do anything; I just sit around not doing very much. This person had a 'socialising care plan' which stated, 'encourage to remain occupied and to attend activities'. This person told us they enjoyed gardening, we did not see any evidence that they were being supported to follow this interest. A member of staff told us, "The activities are sometimes dull…people in their rooms get less, this needs to be improved". We looked at the number of recorded activities for three people cared for in their rooms on the Nightingale unit. None of these had any activities recorded for November. One person had one activity recorded in October. The activities noted were more a record of interactions with people, for example, one said, 'saw [the person] in the morning and after lunch, spoke with them both times briefly'. There was no evidence in these records that people were receiving regular and meaningful activities. Improvements are therefore needed to ensure that when people are cared for in their room, they are still enabled to take part in leisure activities that are meaningful to them as this helps to maintain and improve their quality of life.

Other people were supported to take part in a programme of planned activities. The activities co-ordinator and a volunteer facilitated an arts and crafts session which was well attended. People were being supported to make Christmas cards which they appeared to enjoy. We were informed that one of the activities staff was on an extended absence and that this had impacted on the range of activities being offered. Most people told us they enjoyed the activities on offer. One person said, "I enjoy musical bingo, I join in with the things I like…I am looking forward to the talk about the byways of Romsey". Another person said, "I like the art class and I enjoy music, there was a young lady singing yesterday and before that there was a man who played the bugle and guitar, it's like a party, we have tea, it's quite pleasant". Another person told us how they used the community bus to visit the library.

People knew how to make a complaint and information about the complaints procedure was displayed within the home and included in the service user guide, including how to raise concerns with the Care Quality Commission. One person told us, "If I was concerned or had a complaint, I would tell the nurse that came to me". Another person said, "I would have no hesitation in speaking to anyone". A relative said, "if my mother is in pain, I will tell a nurse, concerns are acted upon". We looked at the records of complaints received by the home. These had been fully investigated in a timely manner and action taken to address the concerns. For example, one person had complained about their food. The manager held a meeting with the person and their family. Actions were agreed which achieved evident improvements.

Focused inspection 10 April 2015

The provider had developed a plan to address the areas where our last inspection had identified concerns. At this inspection we found that some improvements had been made. The diabetic care plans for three people had been updated and included more detailed guidance for staff on how to manage their needs or respond to changes in their health and wellbeing. However, we did note that in two of the care plans additional information would help to ensure staff were able to respond if the person experienced low blood sugar levels as well as high blood sugar levels. A third person's plan needed more information about the signs or symptoms which might help staff identify the person's diabetes was becoming unstable. Following the inspection the provider sent us information which confirmed that these additions had been made.

Improvements had been made to ensure that more accurate records were being maintained of the care and treatment people received. We viewed eight people's daily records and found that overall, these were fully completed. Fluid charts showed that people were being offered regular fluids and the total amount of fluids taken each day was being calculated. We did find that two people's fluids charts and one person's repositioning chart contained a small number of gaps. We spoke with the provider about this and they are to take additional action to ensure that each person has a fully completed record of the care and support they have received. This is important as it helps staff to monitor and evaluate the effectiveness of the care plan in meeting the people's needs.

Overall it was evident that the service was taking action to personalise and improve the level of detail contained within people's care plans. Some people who were at risk of choking had very detailed choking care plans. One person had a detailed breathing care plan which would help staff to minimise this person's risk of getting a chest infection for example. A short term or acute eating and drinking care plan had been put in place for one person who was experiencing swallowing problems. A person who was at risk of falls had a detailed, 'maintaining a safe environment' plan which described how staff should

Requires improvement

Is the service responsive?

support this person to manage their risk of falling. However further progress was needed to ensure that each person's care plan contained all of the relevant detail and guidance required by staff. For example, one person's care plan contained conflicting information about whether they were able to use their call bell to seek assistance from staff. One person's pain plan did not include details of the signs or behaviours which might indicate that they were in pain. Since the inspection, the provider has sent us updated care plans which address these omissions.

A number of measures had been put in place to drive on-going improvements of the records of people's care and treatment. The provider had arranged for the home to have additional support from both its clinical operations manager, compliance team and from managers of other homes run by the provider. Detailed audits were being undertaken of each care plan and these highlighted clearly where improvements were still needed. Staff had received training in care planning to enhance their skills and knowledge and they were being encouraged to take accountability for, and to be part of, the work underway to improve people's records. Night and day staff had been allocated specific areas of accountability for reviewing an updating which linked with their primary roles within the home. The provider was recruiting for unit managers for each of the floors to provide an additional level of oversight, development and support which would include ensuring care plans and records remain accurate and fit for purpose. Staff meetings were being held monthly and we saw that staff were being regularly reminded of the importance of keeping records up to date and of updating care plans in a timely manner.

We found the provider had taken sufficient action to meet the requirements of the warning notice. These improvements will need to be embedded and sustained to ensure that each person continues to have an accurate, complete and detailed record of their needs and of the care they have received.