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

Overall summary

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

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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 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

Summary of findings

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 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.

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?

Requires Improvement

The service was not always safe.

Staffing levels required improvement to ensure that people's needs were met in a timely and consistent manner.

Medicines were not always managed safely for people and records had not always been completed correctly.

Risk assessments had been undertaken which contained detailed and specific guidance to support staff to move people in a safe and effective manner.

Staff had a good understanding of the signs of abuse and neglect. They were aware of what to do if they suspected abuse was taking place.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always receiving care in line with their care plan which could place them at increased risk of deterioration in their health and wellbeing. Aspects of people's healthcare were not always being adequately monitored.

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.

Whilst staff told us they felt well supported by the management team. Further improvements were needed to ensure staff received all of the training relevant to their role and regular supervision.

The home maintained effective working relationship with a number of health care professionals which helped to ensure people received co-ordinated care, treatment and support.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff did not always treat people in a manner that demonstrated to the person that they mattered and that their wishes and choices were valued.

Most people told us that the staff were kind and caring and treated them with respect. We saw some kind and compassionate interactions between people and staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

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.

Is the service well-led?

Requires Improvement

The service was not well led because as aspects of the service required improvement.

The home did not have a registered manager in place.

We found a number of concerns during the inspection which had not yet been identified by the provider. This showed a lack of a robust quality assurance system.

There was an open and transparent culture within the home and the engagement and involvement of people and staff was encouraged. The manager had a vision for the future of the service and clear plans about how the home could improve and offer high quality care.

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 inspection took place on 24 and 25 November 2014 and was unannounced.

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 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.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Marie Louise House. One person said, "Yes they treat me very well". They told us they had no concerns and added, "I would tell my family if there was anything wrong". Visitors told us their relatives were safe. One relative said, "My relative had had falls, staff have a mat sensor next to their bed so that they know when they move about. I feel they are very safe".

Whilst people told us they felt safe, through our observations and discussions with people and staff we found aspects of the care provided was not always safe.

Staffing levels required improvement to ensure that people's needs were met in a timely and consistent manner. Comments from people included, "Staff don't have time" and "They are always so busy". One person told us, "There are not enough staff. I can hear buzzers – someone had to wait half an hour recently, staff say in a minute, in a minute, I know it's difficult but……". A relative told us, "I would like more regular staff, it's not great with different staff all the time". Rotas showed that agency staff were required on a daily basis. A person told us, "I ask agency staff what I am suffering from; they look at my notes and tell me, I say, what's that, they say I don't know, I'm not impressed". A care worker said, "It's difficult when there are agency staff, there is no time to train them or explain to them about people's needs. Its constant pressure, it's not fair if you have to step into people's room with a face that says I am under pressure".

All but one of the staff told us there were not always enough staff to manage people's needs. One care worker said, "I have to leave people when I am feeding them to answer call bells". Another care worker told us how they needed to lock themselves in people's room whilst supporting them to prevent other people wandering in. This practice indicated that there was not enough staff to adequately supervise people. A third care worker told us, "Sometimes drinks might not be given and repositioning and toileting might be missed, particularly for those that cannot call for themselves". When we looked at people's records, these indicated that people were not always receiving their care in line with the frequency as stated in their care plans, although we were not able to clearly ascertain whether this was due to poor record keeping or was an indication that people were not receiving the required care and support.

We reviewed the rotas for the week of the inspection and the three previous weeks. We were told that staff numbers were based on the number and dependency of people using the service and we could see that a dependency assessment tool was in use to inform target staffing levels. Whilst agency staff were used to cover absences, on ten occasions during the period from 14 to 29 November, shifts were short of one member of staff. We were concerned that this increased the risk that people's needs might not be met in a timely way.

There were not always sufficient numbers of staff available to meet people's needs. People were not adequately supervised and had to wait for support. This is a breach of regulation 22 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which now corresponds with Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The management of medicines required improvement. Medicines were not appropriately requested and obtained. Two medicines had been over ordered; leading to an accumulation of these medicines. Medicines were not always safely kept. One Controlled Drugs (CD) safe was not compliant with legislation as it was not adequately secured to the wall. Whilst the treatment rooms had self-closing doors with key code entry, one treatment room door was held open to cool the room, allowing access to an unlocked medicines refrigerator. Appropriate arrangements were not in place to store medicines within their recommended temperature ranges. The service had two medicines refrigerators and both sets of records suggested the refrigerators had been significantly outside of the recommended temperature ranges. The room temperature records for one treatment room showed that the room had been outside of the recommended temperature range during 11 of last 22 records. Storing medicines at the correct temperature is important as this ensures that they are safe to use and remain effective.

Medicines administration was recorded appropriately, but lacked supporting information. Whilst some information was available for "variable dose" and "if required" medicines, this only replicated the medicine label and did not provide sufficient guidance for staff about when these should be given. Information on "how I take my medicines" was not available. Covert administration of medicines had been authorised for three people by their GP, whilst a cognitive assessment had been undertaken, we were

Requires Improvement

Is the service safe?

unable to find records of a mental capacity assessment, best interest meeting or pharmacist confirmation of the suitability of the medicines for covert administration. There was a risk that this was not in the best interest of the three people receiving covert medicines.

Medicines were not always administered safely, on one day a person received three doses of a "twice daily, if required medicine" and another person was administered twice the prescribed dose of a "variable dose, if required medicine" on 12 occasions. One resident had a medical condition requiring 'rescue' or emergency medicines. The associated care plan lacked sufficient detail about how and when these should be used. One person had a documented allergy to an antibiotic; however the staff administered this medicine to the person which resulted in them experiencing an allergic reaction. Two people were prescribed a drug "to be taken as directed", their records indicated the medicine had been administered each morning; however this had not be clarified with the prescribers.

Medicines were therefore not always appropriately requested or stored and medicines were not always administered safely. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which now corresponds with Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

Improvements are needed to the way in which agency staff were informed about people's current needs. Daily handovers were not always effective at ensuring agency staff were informed and aware of key risks to people's wellbeing. For example, an agency nurse told us they had received a handover when coming on shift, but when we talked to them about some recent updates about a person care needs, they explained that this information had not been shared with them.

People's records contained appropriate risk assessment which covered a range of areas. For example, risk assessments had been undertaken to identify whether people were at risk of choking when eating. 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 told them what they needed to know about each person and how to deliver their care safely.

Most staff had received training in safeguarding adults at risk 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. The organisation had appropriate policies and procedures. This ensured that staff had clear guidance about what they must do if they suspected a person was being abused. Staff were informed about the provider's whistleblowing policy. Staff were clear that they could raise any concerns with the manager of the home, but were also aware of other organisations with whom they could share concerns about poor practice or abuse.

Records showed staff completed an application form and had a formal interview as part of their recruitment. The provider had obtained references from previous employers and checked with the Disclosure and Barring Service (DBS) before employing any new member of staff. The registration details of nursing staff had been checked with the body responsible for the regulation of health care professionals and these checks were repeated on an annual basis. These measures helped to ensure that only suitable staff were employed within the home. We did note that in two of the staff records that we reviewed a full employment history had not been obtained. Following the inspection, the manager confirmed to us that they had now obtained and verified this information.

Requires Improvement

Is the service effective?

Our findings

Most people told us that they received effective care from staff that were well trained and had the skills to support them. One person said, "The staff are skilled". A relative said, "The staff are excellent, they have a difficult job which they do very well". Another relative explained how their parent had returned to the home after a short break with a stomach bug. They said that the home had managed their care effectively and ensured that they recovered quickly and that no-one else got the bug.

At our last inspection in June 2014, the provider had not always been delivering effective care as care plans provided insufficient detail about key risks to people health and welfare. The provider sent us an action plan saying how they would make the required improvements. At this inspection, we found that the provider had not made the required improvements.

People were not always receiving care in line with their care plan. One person required four hourly repositioning to prevent damage to their skin. Staff were required to document these changes of position on a chart. Audits undertaken by the home on the 12 November and 18 November 2014 had identified that there were gaps in this person's charts. When we inspected on 24 November, there were still gaps in these records. We raised this as a concern with the manager and asked that action be taken to ensure that this person was receiving care as outlined in their care plan. However, we were sent records following the inspection which still indicated that this person was not being repositioned in line with the frequency stated in their care plan. We could not be assured that staff were meeting this person's needs. We were concerned that they could be at increased risk of damage to their skin because of this.

One person was prescribed food supplements. Their care plan stated that they were intolerant to a certain flavour; however, we found a pack of supplements in this flavour in their room. Two of the packs were missing indicating they had been used. We spoke with a nurse who confirmed that the person was intolerant to this flavour and removed these. Records for another person suggested that they had not received support to manage their personal care on 13 days in November. We could not be assured that this person had received care that was in line with their care plan. Another person told us about how they were feeling in a very low in mood. This person's depression assessment tool had not been updated since May 2014. We were concerned that this person's mental wellbeing was not being adequately monitored.

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. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010 which now corresponds with Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected this service in June 2014, we found that mental capacity assessments had not always been carried out in line with the Mental Capacity Act 2005. Staff had not had Mental Capacity Act training and they lacked knowledge about mental capacity and what this meant for the people they supported. At this inspection, we found that some improvements had been made. Staff had received training. Each person's care plan contained an 'Assessment of Decision Making Capabilities' form. This form recorded some useful information such as whether the person had a legally appointed representative such as a Lasting Power of Attorney. However the form did not require or guide staff to apply the principles of the MCA when assessing a person's capacity. These principles put in place a range of safeguards which aim to enable and support the person lacking capacity rather than restrict or control them.

The MCA 2005 states that any decision made on behalf of a person who lacks capacity must be made in that person's best interests. Staff at the home had been involved in a best interests meeting for one person. However we saw other examples where people had been assessed as lacking capacity to make a decision but no best interest's consultation had been undertaken. For example, one person had a cognition plan which stated that they were unable to make any decision relating to their care. In this person's pain plan, it stated, 'it is felt it is in [the person's] best interests to give 20mls of paracetamol every morning, so that there is no pain during personal care'. There was no mental capacity assessment to underpin this decision and no evidence of a comprehensive best interest's consultation with others such as relatives, and friends engaged in caring or treating the person. There was a risk that this was not in the person's best interest. For another person, there was no clear mental capacity assessment in

relation to the use of covert or hidden medicines. Whilst it was recorded by a health care professional that it would be in the person's best interests to use covert medicines, there was no evidence of wider consultation with relevant people about this decision.

Further improvements were therefore needed to the arrangements in place for assessing people's mental capacity. Mental capacity assessments were not being completed appropriately. Records relating to decisions made in people's best interests were not always documented or reviewed in line with the requirements of The Mental Capacity Act 2005. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which now corresponds with Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that 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 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.

When we inspected this service in June 2014, staff did not have all of the training relevant to their role. During this inspection, we found that some improvements had been made, although some staff had still not completed all of the training relevant to their role. For example, five registered nurses had not completed infection control training. Fourteen staff were yet to complete training in safeguarding adults. However staff seemed to have a good understanding of their role and responsibilities in relation to safeguarding people and were able to tell us how they would respond to protect a person from harm.

A senior member of staff had been appointed to take charge of overseeing the training programme and ensure that staff were up to date with essential training. Training was delivered in two different ways; e-learning and face to face training. Two members of staff told us the training they received was useful. One registered nurse told us, they had completed additional training in order that they could meet people's needs more effectively. This included a qualification that enabled them to cascade training to other staff on dementia care and moving and handling people safely. A care worker, told us that they had just started a distance learning course in medicines management and was undertaking training that would help them support and care for people at the end of their life. They said, "Whatever I ask for, it is arranged straight away". This helped to ensure that staff were developing the skills and knowledge they needed to meet people's needs.

New staff received an induction which involved shadowing more experienced staff and learning about the needs of the people using the service and the policies and procedures of the home. Records showed that the induction of new staff was in line with Skills for Care Common Induction Standards (CIS). These are the standards people working in adult social care should aim to achieve within their first 12 weeks. They help to demonstrate that the care worker understands how to provide good quality care and support.

At our previous inspection in June 2014, we found that staff were not receiving regular supervision. At this inspection, some improvements had been made. A supervision tracker had been put in place to assist the manager in planning supervisions for the year and to ensure that staff were aware of when they were expected to attend supervision meetings. However records suggested there were still six registered nurses, two senior carers and six care workers who had not yet received supervision this year (2014). Whilst staff told us they felt well supported by the management team without regular supervisions there was a risk that staff would not receive the guidance they required to develop their skills and knowledge and understand their role and responsibilities. Further improvements are therefore needed to embed the supervision arrangements within the home.

People's nutritional needs were met. Drinks were readily available throughout the day and we frequently observed staff encouraging people to drink fluids. The meals were home cooked, freshly prepared and well presented. One person told us, "The food is very nice, nourishing, if I don't like it they will get me something else". Another person told us, "The menu is shown to us the night before and we can choose". A relative said, "The kitchen staff are very good, we can have meals here with my mum". The meal-time

Requires Improvement

Is the service effective?

experience appeared to be enjoyed by people, there was music playing and people were able to choose their vegetables from a platter at the table. One person told us, "There are three of us on our table and we do chat". Information about people's likes and dislikes in relation to food had been recorded in their care plans and was kept in the kitchen and regularly updated. The chef was informed about people's allergies and special diets including those people that required a fortified diet. Staff had liaised with professionals such as speech and language therapists (SALT) to inform nutrition plans and manage identified risks such as swallowing difficulties. Information provided by the SALT was displayed in the bedroom of one person who ate their meals in their room. We saw that this guidance was being followed.

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. A social care professional who told us, "I am confident they respond to any suggestions and support we offer to ensure good delivery of people's care".

Requires Improvement

Is the service caring?

Our findings

Whilst most people thought the staff were kind and attentive, three people did not feel this was always the case. They also told us that staff could involve them more in decisions about their care and how or when this was provided. One person said, "The staff are generally kind and caring, but sometimes they take me into a room where I don't want to go. Sometimes, I'm told, not asked, but they do try and are kind and involved when they have the time". Another person told us, "Some staff are kind and caring, some are quick and blunt, I don't like them but there aren't many like that". A third person said, "Staff don't talk to you, they just see to what is necessary". Our observations indicated that staff were primarily engaged in completing routine care tasks. While they were friendly towards people, their interactions were often quite brief. One staff member told us, "We would like to spend more time with people, but we cannot, we can barely get the care done, there is just not enough time. This indicated that people were not always treated in a caring and compassionate manner.

We observed that people's wishes and choices were not always listened to. For example, one person had expressed a wish that staff support them to take their lunch in a particular place. It was clear to us that this was very important to the person. Staff responded by telling the person, they would assist them after lunch. This was dismissive of the person's wishes. The person told us, "I don't' know why they can't let me go, there is too much red tape, they know I don't want to be here [dining room], but they won't let me go". We heard a group of people chatting about how their bedroom windows had been left open again despite them asking that they be left closed. Improvements are therefore needed to ensure that all staff understand what is important to people and that all staff respond and interact with each person in a manner that demonstrates to the person that they matter and that their wishes and choices are valued.

There were some good interactions. We observed staff using touch to reassure people who were anxious but also to display warmth and regard for the person. Most people appeared relaxed and comfortable in the presence of their carers. We observed friendly and light hearted chat between people and their carers. We saw a care worker helping a person to eat and drink. They spoke to the person in a kind and attentive manner, for example, we heard them say, "You're doing really well, are you ready for your next mouthful". We saw a nurse sensitively assisting a person to take their medicines, they said, "We'll take it slowly, it's not bad, just try". They praised the person when they had taken the medicines and their interactions were encouraging throughout. One care worker told us, "I love making the residents smile".

One person described the staff as "Thoughtful and kind". They added, "I am treated well". Another person said, "All the staff are kind and caring, I can't say anything bad about any of the carers. A third person said, "They all treat me very well, I can't think of anything they [care workers] could do better. Comments from relatives included, "The care is fantastic, excellent" and "They treat my mum perfectly well". A healthcare professional told us, "the residents always appear to be treated with dignity and respect. The staff seem to be caring and positive towards the residents and understand their individual needs". A social care professional said, "The staff showed strong compassion and caring attitudes… they were supportive and understanding".

Staff were mindful of people's privacy. They told us how were careful to close doors when providing personal care and knocked on people's doors before entering. The importance of maintaining people's privacy and dignity was described in people's care plans.

People were supported to remain as independent as possible. One person told us how staff helped them to bathe, but encouraged them to do as much for themselves as they felt able to. At lunch time, we saw a care worker assisting a person to drink. They offered just the right amount of support, guiding the drink to the person's mouth at which point they were able to complete the task independently. The need to encourage people to be independent was also evident in people's care plans, for example, we read, 'encourage [the person] to be independent by enabling them to wash their own face and arms'.

People's relatives and friends were able to visit without restrictions. We observed relatives visiting throughout the day and sharing in aspects of their relatives care and support. There was a poster in the lifts welcoming visitors and encouraging them to make themselves hot drinks. Relatives appeared to have a good relationship with the staff.

Requires Improvement

Is the service caring?

People were actively supported to maintain their religious and spiritual beliefs and saw this as 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 along with lay members of the local community. During our inspection, a special mass was held in memory of all the people who had been cared for at the home but had now passed away. This was a moving experience and was well attended by relatives and people.

The manager demonstrated a commitment to ensure that the home provided sensitive and compassionate end of life care to people. This commitment was shared by the staff we spoke with. One care worker told us about being supported to provide care after death to one person. They told us, it had been a very moving and dignified experience. Another care worker told us, "The home offers really good palliative care, we are not ashamed to cry". The home was working towards obtaining accreditation in the Gold Standards Framework (GSF). Homes that have GSF accreditation have demonstrated that they appropriately assess, plan and deliver care to people nearing the end of life. One person had an end of life care plan which recorded their wishes in relation to how they were to be kept comfortable and pain free and their views in relation to how their nutrition was managed to avoid hunger or thirst.

Requires Improvement

Is the service responsive?

Our findings

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 can't go anywhere, or do anything; I just sit around not

Requires Improvement

Is the service responsive?

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.

Requires Improvement

Is the service well-led?

Our findings

People said they had no concerns about the leadership of the home, although some expressed uncertainty about who the manager was. One person said, "I am not sure who the manager is". Another said, "I don't see the matron, but it seems well led". Another person said, "The manager and matron could come round to see us all more, I go down to speak with them, but I feel like saying 'hello computer'…everyone is so busy". A relative said that there had been a period of instability in terms of management, but that they were hopeful that the new manager would bring stability to the home.

During our last inspection in June 2014, we found the systems in place to assess and monitor the quality of the service, had not been fully effective. The provider's action plan stated that they would put in place a monthly audit plan and other measures to help identify and achieve the required improvements. At this inspection we continued to identify concerns in a number of areas including; how mental capacity was being assessed and recorded, the care and welfare of people, and the robustness of records relating to people's care. Audits had not always being used effectively to deliver improvements in the quality of care. We were unable to see any evidence of care plan audits taking place between July and Oct 2014. This is contrary to what the provider told us they would do in their action plan. Medication audits were not being undertaken. This meant that the management team had not identified the concerns we found in relation to how medicines were managed within the home. This indicated that overall, there continued to be a lack of a robust quality assurance system in place. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which now corresponds with Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Some aspects of the service were more effectively monitored through the use of audits. Weekly and monthly reports were produced by the manager for the provider. These reported on complaints, maintenance issues, adverse incidents, infection control and the progress of those who had been assessed as nutritionally at risk. We were able to see that action was taken to achieve improvements or prevent similar incidents.

The provider and the new management team had started to put other arrangements in place to strengthen the quality assurance processes. A clinical auditor had been appointed who was spending time in the home supporting the manager to identify the areas which required improvement and develop an action in response to these. An infection control audit and an audit of care records had taken place prior to our visit in November 2014. These audits had identified some shortfalls or concerns, in response to these the manager had taken action to remind staff of their responsibilities in relation to maintaining accurate records for example. These improvements will need to be embedded in practice and sustained in order for the service to demonstrate that it has effective systems in place to ensure the delivery of safe and high quality care.

Marie Louise House had a newly appointed manager who had only been in post for six weeks at the time of our inspection. They planned to submit an application to The CQC to be appointed registered manager. The manager was still getting to know the home, the people living there and the staff. The manager was actively working to develop their understanding of what the home did well and the areas it needed to improve on. They were beginning to formulate a vision for the service. They told us they wanted the home to move away from a culture of task led care to one which was more about the quality of care people received. They told us that they were aware that the home faced some challenges at present, but were committed to making the necessary improvements. The manager had already prepared a plan which detailed how they hoped to achieve improvements such as making the care plans more specific and personalised. They talked to us about their plans to have a more robust induction programme which helped to ensure that staff began their work within the home equipped with all of the skills and knowledge they needed to provide effective care. They aimed to enhance the competency testing which would be used periodically to check the skills of care workers and nurses and to highlight any weak areas that needed additional training. Further planned improvements were described in the provider information return. These included plans to update the provider's policies and procedures to make them more personalised to Marie Louise House and to undertake research to inform the introduction of new

Requires Improvement

Is the service well-led?

activities within the home. We saw that better internet access was also planned along with more user friendly resident and staff surveys so that people's views about the service could be used to underpin future improvements.

There was an open and transparent culture within the home and the engagement and involvement of people and staff was encouraged. A residents meeting was planned for the week following our inspection. Two people told us they always went to the resident's meetings, one said, "You can say anything you want and you gets lots of info from the matron". Staff spoke positively about the new manager. They told us they felt able to make suggestions or offer comments about how day to day issues were managed within the home. One care worker said the manager was "Absolutely brilliant, she takes action, she's wonderful". Another care worker said, "They have made a big difference…its feels much more positive…there is better communication about future plans". A registered nurse said, "The manager and the head of care are very visible…they are accessible if we want to talk at any time". They added, "Since I've been here, I've been able to do lots of courses and my competency in things like medicines is assessed every second month. I would say the manager really knows what is going on out here on the floor".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service users' needs and ensure the welfare and safety of the service user.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had not protected service users, against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not protected service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations and identify and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which included appropriate information and documents in relation to the care and treatment provided to each service user.

The enforcement action we took:
Warning notice served requesting the provider to be compliant by 15 February 2015