The Healthcare Management Trust

Marie Louise House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place over two days on 27 and 28 March 2018. The inspection was unannounced.

Marie Louise House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Marie Louise House is a purpose built care home with nursing. The home is a Catholic foundation which regards spiritual welfare to be equally important to physical care. However, people of all faiths were welcome at the home. The home is owned by the Daughters of Wisdom, a Catholic religious order, and managed on their behalf by the Healthcare Management Trust (HMT), a not for profit organisation, and their board of Trustees. The home is registered to accommodate up to 51 people and at the time of the inspection there were 46 people using the service. The home comprises of three units. The Nightingale Unit provides care for up to 10 people who are living with dementia and have associated health and social care needs. The Kingfisher and Skylark Units each provide care to 18 people who require either residential or nursing care.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Overall medicines were managed safely. The registered manager was arranging for additional training to support improvement with record keeping in relation to medicines.

There were a range of systems and processes in place to identify and manage risks to people's wellbeing and to the environment.

Staff had received training in safeguarding adults, and were aware of their responsibilities with regards to keeping people safe from harm.

There were suitable numbers of staff deployed to meet people's needs.

The home was clean and staff were observed to be using appropriate personal protective equipment (PPE).

Accidents and incidents were investigated and action taken to reduce the risk of further harm.

Care plans provided a record of people's individual needs and staff were provided with opportunities to develop their skills and knowledge and performed their role effectively.

Staff worked in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were applied appropriately.

People were supported to have enough to eat and drink.

The premises were purpose built and their design and layout met the needs of people using the service. A programme of refurbishment was underway.

Where necessary a range of healthcare professionals including GPs, dentists and speech and language therapists, had been involved in planning people's support to ensure their health care needs were met.

People were cared for by kind and compassionate staff and were treated with dignity and respect.

Feedback showed that staff provided effective and compassionate care to people reaching the end of their life.

Improvements had been made to develop the activities programme provided and action was being taken to extend the activities provision to include weekends.

Communication was provided in ways which met people's individual needs and technology was used to support people to maintain choice and control as to how aspects of their care were delivered.

People and relatives told us they were confident they could raise concerns or complaints and that these would be dealt with.

The service was well led. Staff were positive about the leadership of the service and felt well supported in their roles. Staff morale was good and staff worked well as a team to meet people's needs.

There were robust systems in place to monitor and improve quality and safety within the service. The provider sought feedback from people, their relatives and from staff and used this to continually improve the service.

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 remained good.	**Good**
Is the service effective? The service remained good.	**Good**
Is the service caring? The service remained good.	**Good**
Is the service responsive? The service had improved to good.	**Good**
Is the service well-led? The service remained good.	**Good**

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 checked 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 27 and 28 March 2018. On the first day of our visit, the inspection team consisted of three inspectors, an inspection manager 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. On the second day, the team consisted of two inspectors.

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. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as 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.

During the inspection we spoke with fourteen people who used the service and five relatives and five visitors. We spoke with the registered manager and four registered nurses. We also spoke with five care workers, two activities staff, the chef and maintenance team. We reviewed the care records of eight people. We also looked at the records for four staff and other records relating to the management of the service such as audits, incidents, policies and staff rotas.

Following the inspection we received feedback from five health and social care professionals and asked their views about the care provided at Marie Louise House.

We last inspected the service in November 2015 and rated the service as good overall. The 'Responsive' domain had been rated as 'requires improvement'. This was because people's records were not always sufficiently detailed. We had also made a recommendation regarding the activities for people living with dementia. This inspection found that improvements had been made in both areas.

Good

Is the service safe?

Our findings

The people we spoke with felt safe living at the home. One person told us, "I do feel safe here. There's always someone around and the staff are so lovely". A relative told us, "It's such a relief to know they're in good hands. You hear so many tales about bad care but it wouldn't happen here".

We looked at how the service managed people's medicines. Medicines were stored appropriately within locked trolleys or a designated medicines fridge, kept in locked treatment rooms. The temperature of the fridge and treatment rooms was monitored appropriately. Controlled drugs were stored securely and the records relating to these were complete. Controlled drugs (CDs) are medicines which are controlled under the Misuse of Drugs Act 1971 and which require special storage, recording and administration procedures. Staff administering medicines had received training and had their competency to administer medicines safely assessed on an annual basis. We observed a medicines round. This was managed in a safe and person centred manner. Appropriate policies and procedures were in use for the use of homely remedies and the covert administration of medicines was being managed in line with legislation.

We did find that some improvements could be made with regards to record keeping. For example, two people's records gave inconsistent information about whether they had any allergies. Personalised protocols were not consistently in place which described the circumstances in which people might need their 'variable dose' or 'if required' (PRN) medicines. Staff completed topical medicines administration records (TMARS) but these did not include details of where and with what frequency the topical creams should be applied. Staff knew people well and handover was used to reinforce information about people's needs and where, for example, creams needed to be applied. We discussed our findings with the registered manager who took prompt action to ensure these were addressed. They have also provided confirmation that additional training has been booked for the 1 May 2018 which will cover all of the areas where our inspection noted improvements could be made to medicines records.

Staff completed a range of health and safety checks to help identify any risks or concerns in relation to the environment and equipment used for delivering people's care. For example, regular checks were undertaken of fire safety within the service. A fire risk assessment had been completed in August 2017, following which no actions had been required. People had personal emergency evacuation plans (PEEPs) which detailed the assistance they would require for safe evacuation of their home. A business continuity plan was in place and set out the arrangements for ensuring the service was maintained in light of foreseeable emergencies. Checks were also being made to manage the risks associated with legionella and adjustments had been made to ensure that the temperature of the hot water in people's rooms did not present a risk of scalding.

There were a range of systems and processes in place to identify and manage risks to people's wellbeing. Each person had a range of individual risk assessments which had been evaluated regularly. For example, moving and handling risk assessments were in place. These were detailed and well written and considered a range of factors that could impact upon the person being moved safely and efficiently such as their behaviour and pain levels. Risk assessments were also in place which helped predict whether people were,

for example, at risk of falls or of developing pressure ulcers. Where people were at risk of choking, risk assessments had been completed and a choking care plan was in place which gave clear instructions for staff on how to prevent or manage emergency situations. Bed rail risk assessments had been completed and regular checks made to ensure that the rails were being used safely and the risk of entrapment reduced.

Where risks had been identified, remedial actions had been taken. For example, one person had been referred to the falls prevention team and another person had given consent for sensor mats to be placed in their room to alert staff that they were moving around, particularly at night when they were most at risk of falls. Staff were not overly risk adverse and following appropriate risk assessments, people were, for example, self-administering their medicines.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. The provider had appropriate policies and procedures which made links to the local authority's multi-agency safeguarding procedures. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. Staff were aware of whistle-blowing procedures and were clear they could raise any concerns with the registered manager and other organisations if they were concerned about poor practice or abuse in the service. One staff member said, "I would report anything like abuse to the manager. She wouldn't stand for it".

The registered manager used guidance from the Royal College of Nursing to inform planned staffing levels and told us this was reviewed regularly to check whether any action was needed to increase the numbers of staff deployed across the three floors. A team of bank staff was used to cover vacancies, staff annual leave or sickness and occasional agency use was required. Overall, we observed that call bells were responded to promptly and records seen confirmed this to be the case. Most people told us there were sufficient staff to meet their needs. For example, one person said, "Well, I don't wait if I need help. I call and they come" and another told us," I've only used it once and they came straight away". A visitor told us, "I don't see the staff rushing to be honest. They seem to have enough time to care for people properly". Staff were mostly positive about the number of staff deployed. One staff member said, "I think so. There are usually enough [staff] to cope". Another staff member told us, "We haven't had to use agency for a long time now. I think we are properly staffed". Despite this feedback during the inspection, concerns about staffing numbers and staff having the time to spend talking with people was identified as one of the primary concerns in the recent relative's survey. The registered manager told us they were confident that staffing levels were safe and they and the provider would be reviewing the outcome of the surveys shortly and producing an action plan in response to this.

Overall recruitment practices were safe and relevant checks had been completed before staff worked in the service unsupervised. These included identity checks, obtaining references and Disclosure and Barring Service checks. These measures helped to ensure that only suitable staff were employed to support people in the service. Checks were also made to ensure that the registered nurses were registered with the body responsible for the regulation of health care professionals. We noted that in the case of three staff members, a full employment history had not been obtained. We spoke with the registered manager about this who took immediate action to obtain and document the information. They also advised that a full audit would be completed of all staff files and additional measures put in place to prevent any reoccurrences.

Staff had a good understanding of infection prevention and control issues and all areas of the home, both communal and clinical, were clean and tidy. We did not detect any lasting malodours during our visit. People had individual infection control risk assessments in their care plans and there were ample hand hygiene stations throughout the home. Bathrooms and toilets were found to be clean and free of litter or

debris. Whilst cleaning schedules were in place, these had not always been fully completed, although the registered manager assured us that cleaning was undertaken on a daily basis. The kitchen was clean and the service had recently been awarded the highest rating following a food hygiene inspection.

Incidents and accidents which occurred in the home were recorded and we were able to see that action was taken as a result of safety incidents to ensure lessons were learnt. For example, we identified two administration errors where people had not received their medicines as prescribed. The registered manager ensured that reflective supervisions took place with the staff members concerned to help prevent reoccurrences and to improve safety across the service. The registered manager prepared monthly reports for the provider which recorded the number of incidents, infections, safeguarding concerns or wounds. This enabled any trends or themes to be identified, learning to be shared and also enabled the provider to have oversight of risks within the service.

Good

Is the service effective?

Our findings

People were positive about the care they received. One person told us, "I like the people, my room, the food and what we do". Another person said staff were, "Excellent, truly excellent….They get me up, wash me, bath me once a week. I wallow in the bath, its luxury." A third person described their care as "A1". One relative told us, "This home is streets ahead of anywhere else we have been to…staff go above and beyond" and another said, "If I had to go anywhere, I would be happy to come here".

Before a person came to stay at the service, a comprehensive assessment of their care needs was carried out to gather information from the person and where appropriate from their relatives and any professionals involved in their care. This helped to ensure that appropriate decisions were made about whether the service would be able to meet the person's needs. These initial care plans were used as the basis for more comprehensive care plans which described the person's needs in a range of areas such as personal care, eating and drinking, mobility and social activity. Where necessary, people had condition specific care plans describing their needs in relation to a range of conditions. For example, one person lived with Parkinson's Disease. Their Parkinson's care plan contained up to date and relevant information about how this affected the person and what staff input was required to provide effective care.

There was evidence that care and treatment was being delivered in line with a range of evidence based guidance and clinical pathways. For example, staff were effectively using the (NEWS)2 (National Early Warning Score) tool to support staff in identifying people who may need to be reviewed by their GP. (NEWS)2 is a tool used to improve the detection of acute deterioration in people, potentially caused by life threatening conditions such as sepsis and is seen by NHS England as a key factor in improving health outcomes for people.

The registered manager had undertaken a self-assessment of the dementia care provided within the service, using this to baseline the current care provision against the Department of Health's dementia pathway. An action plan had been produced as a result, most of which had already been completed. Clinical governance meetings were taking place and working well as a tool to share skills and knowledge and problem solve amongst the nursing team.

New staff received an induction to the home during which they spent time learning about their role and responsibilities and the provider's values, philosophy of care and key policies and procedures. They were allocated a mentor who supported them and also had opportunities to shadow the more experienced staff. Inexperienced or staff new to care completed the Care Certificate. The Care Certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate.

The provider designated certain training as mandatory and this was provided mostly through an online training system. This included subjects such as moving and handling, Mental Capacity Act 2005, fire training, infection control, safeguarding, equality and diversity, food safety and first aid. This training was mostly up to date or was due to take place shortly. Staff were able to complete additional training relevant to the needs of people using the service. For example, falls awareness, continence care and dysphagia (difficulty

swallowing). Staff received training on dementia care and they, along with relatives, had been provided with an opportunity to take part in a virtual simulation of the challenges that people living with dementia may experience in their everyday lives. Staff were positive about the training provided. One staff member said, "It's wonderful. I have been on training in London which was really good".

The registered manager recognised the individual skills and knowledge of staff and encouraged them to extend their roles and responsibilities and undertake additional qualifications in order to ensure that care was provided to people by staff who were knowledgeable and aware of current best practice. For example, staff had become champions (experts) in a variety of areas such as dignity, moving and handling and dementia care. The champions served as role models but had also given talks to staff to help develop their understanding of the subject. One staff member told us, "It's really good, I've just done my NVQ2, the manager is really keen we get proper training". Another staff member told us they had been, "Supported and encouraged to go further".

The provider was committed to supporting registered nurses to gain their revalidation and had supported staff to attend external training in a range of clinical skills. Revalidation is the way in which nurses demonstrate to their professional body they continue to practice safely and effectively and can therefore remain on the nursing register. Throughout the process of revalidation, nurses received both peer and managerial support. One registered nurse told us, "I've done verification of expected death and catheterisation training. I've done so much since I've been here".

The provider was committed to providing student nurse mentorship and two registered nurses had been trained to assess whether student nurses had the skills, knowledge and competency to practice safely in a range of NHS or health and social care settings. The first student nurse was expected in April 2018.

Staff were receiving regular supervision which they told us was a "Two way process", "Felt honest and open" and assisted them to perform their role effectively. One staff member said, "We get supervision regularly and that's really good. We get to have our say". Registered nurses also underwent clinical supervision by either unit leads or the registered manager, all of whom were nurses themselves. Appraisals were also taking place and discussed the staff member's training and development needs.

Staff sought people's consent before providing care and people were encouraged and supported to make decisions about their care and support. People had signed consent forms in relation to their care plans, to having their documents shared with other professionals and family or other representatives. Where people had appointed a legal representative to make decisions on their behalf, copies of the legal documents were maintained within the service.

Where there was doubt about a person's capacity to make decisions about their care, mental capacity assessments had been appropriately undertaken and documented in line with the Mental Capacity Act (MCA) 2005 which ensured that the person's rights were protected. 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. Records showed that, where it was determined a person did not have the mental capacity to make a specific decision, a consultation had been undertaken to reach a shared decision about what was in the person's best interests. Staff respected the right of those with mental capacity to make potentially unwise decisions. For example, one person had declined the use of bed rails and a lap belt when seated in their wheelchair to help prevent falls. Staff had, however, respected the person's wishes not to use these.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Relevant applications for a DoLS had been submitted by the home and had either been approved or were awaiting assessment by the local authority.

The design and layout of the premises met people's needs. There were a range of pleasant areas where people could choose to spend their day or entertain visitors. People's rooms were spacious and could be furnished with their own personal possessions. There was a small secure outdoor garden with level paths and seating available for people to use and a larger patio area. A larger piece of land, adjoining the home, but belonging to the Daughters of Wisdom, was also available for events as and when required. A home wide refurbishment programme was underway to enhance the environment for people.

People's nutritional needs were met. When people first came to the home, they were visited by the chef who obtained information from them about their food likes and dislikes to ensure that these could be catered for, along with any food allergies or intolerances. People were positive about the food provided and told us that an alternative was always available if they did not like what was on the main menu. People were able to take their meals in the main dining room or in their room according to choice. Overall, our lunchtime observations indicated that staff were attentive to people's needs and where needed supported was provided in a person centred manner. Dining tables were set with cloths, napkins, a menu, a small vase of flowers and an Easter decoration. A selection of hot and cold drinks were available throughout the day and each person we visited had water or juice in their rooms.

Some people required their meals to be served at a specific consistency to minimise the risk of choking and where this was the case, the staff we spoke with were knowledgeable about people's requirements and a variety of referrals had been made to specialists such as dieticians and speech and language therapists. The chef and their team were passionate about presenting the meals in an appetising manner. For example, they piped pureed foods into moulds to make them look more attractive. The chef told us, "It's got to look nice; like I want to eat it myself, it's important it does not look different so that they are not embarrassed". The chef also told us how they tried to visit any people who were not feeling well so that they could offer them the food they felt able to manage or might be tempted by.

Where necessary, people were supported to access a wide range of core and specialist health care services such as specialist nurses, community physiotherapists, occupational therapists dentists and opticians. This helped to ensure that people's healthcare needs were met. For example, one person was an insulin dependent diabetic. We noted evidence of good day to day healthcare, such as referrals to podiatry for foot care and regular eye checks to maintain health for this person.

Each week, a GP attended a planned visit to the home, during which they were able to review people about whom staff had concerns or who were presenting as being unwell. Staff recorded a range of observations for people on a monthly basis and these were used, along with the (NEWS)2 scores, to inform the consultations with the GP. A relative told us, "The GP came and saw [family member] for a chest infection and gave antibiotics, the nurses are checking all the time and call the doctor if needed". Clear records of all communications with health and social care professionals were kept and informed plans of care for people. One healthcare professional told us, "I often give advice which is noted and taken on board".

Good

Is the service caring?

Our findings

People told us they were supported by kind and caring staff. For example, one person said, staff were, "Very kind, very caring, very thoughtful" and another said, "The staff are so caring and lovely, It's really homely". A visitor to the service told us, "I have seen nothing but kindness and consideration shown by the staff to everyone…the staff members are cheerful and show a genuine concern for the wellbeing of the residents".

Many of the compliments received by the service commented on the kind and compassionate manner of the staff team. For example, one read, 'They [staff] were extremely kind and helpful. They were very friendly and struck the right balance between being serious about important things whilst also encouraging us in a cheerful and jovial way'.

Professionals were positive about the caring nature of the service. Comments included, "Staff are friendly… and want to do the best for their residents", "The staff are very attentive to the resident's needs, the interactions I have seen between residents/families and staff are friendly and proactive" and "From our knowledge of the Home, the staff and the overall ethos of the HMT group, we are confident that residents are treated with respect and dignity from the staff who are caring and professional".

Staff interacted with people in a warm and friendly manner and were seen to chat with them about everyday matters such as the news or the planned activities for the day. People responded positively and overall seemed relaxed and contented. A relative told us, "What I love is that a lot of banter goes on". We observed staff being attentive and supporting people in an unhurried manner. For example, we observed one person being supported to transfer to their wheelchair. The staff member took time and care, ensured that the person was assisted correctly and that she had everything she needed including her hand bag and cushion.

Staff spoke fondly about the people they supported and it was clear that they knew them well and had developed a meaningful relationship with people. For example, we observed that staff knew people's food preferences without needing to refer to their care plans. The positive relationships was evidenced by one person who we heard saying to a staff member, "I've missed you, I've really missed you". A staff member told us, "A lot of staff have been here a long time and so we know [people] really well". Some of the people and relatives we spoke with talked about how much they valued the little things staff did that went over and above. For example, a relative told us that a staff member brought their dog in to see their family member which they valued. One staff member told us the best part of their job was "Caring for the residents and contributing to their lives". Staff were confident that all of their colleagues were kind and caring and were clear that if this was felt not to be the case, they would raise their concerns and this would be addressed.

People were supported to maintain the relationships and friendships with those that were important to them and relatives or friends were free to visit at any time and share in their loved one's care. For example, we saw relatives helping their family members to eat and drink or having a meal with them. One visitor told us, "I'm always offered a drink by the staff….they are always helpful and friendly". The importance of helping people maintain their relationships was demonstrated by staff who supported one person to celebrate their diamond anniversary. Staff had arranged for the couple's friends and family to be invited to the home, had

arranged a buffet and laid on decorations. The relative had written to the service saying they 'Appreciated the planning, care in preparation and presentation and thoughtful details of the cake, buffet and the dining room decoration'.

People were also encouraged to be involved, where able, in the running of the home. For example, one person delivered the newspapers and another person spent time with the reception staff where we were told they enjoyed getting 'ribbed' by the staff. This person had on occasion also been involved in interviewing new staff. People were also very much being involved in decisions around the new décor and soft furnishing as part of the current refurbishment plan.

People told us they were treated with dignity and respect and this was also commented on by their relatives and professionals. A stand informing people and their relatives who the dignity champions were, was located in reception and also displayed information about best practice in relation to dignity in care. We did observe a small number of interactions where the support could have been provided in a more discreet and person centred manner. We also observed that in a small number of cases, people's choices were not always sought or listened to. This was not an endemic observation and we have discussed this with the registered manager who has reassured us that the staff involved will be supported to reflect on the interactions and to consider how this might have impacted upon the person.

People's differences and preferences were respected and the diversity of people and staff was celebrated. For example, the home had a diverse workforce and each month, a staff member created a display about their culture, including their national dress, dish and interesting facts. The registered manager told us this helped to create a harmonious workforce, which in turn had a positive impact on the care provided to people.

People were supported to live their life in the way they wanted and staff understood the importance of people being supported to express their sexuality and understood that this was an important part of delivering person centred care and respecting a person's individual rights and choices. The registered manager was aware of their responsibilities in relation to the General Data Protection Regulation and staff had been provided with training supporting them to understand the importance of protecting people's personal information.

People were provided with opportunities to follow their religious beliefs. The home continued to have close links with the Daughters of Wisdom, a religious order living in the adjacent convent. People were able to attend mass at the home and receive regular visits from the clergy. An ecumenical pastoral team were also available and could be contacted at any time to pray with people, support any spiritual requests or just to sit with people approaching the end of their life. The pastoral team were also available to support staff if this was required. A professional commented on the pastoral support saying, "There is a strong emphasis on pastoral care of people's particular needs, including their religious needs; in relation to the Roman Catholic residents they have the regular support of an active and dedicated team of pastoral visitors three times a week.

The registered manager and provider promoted an ethos of caring not only for the people using the service but also for the local community. For example, at Christmas, staff had visited local people living alone and taken them a meal, a cracker and a gift. One person had been involved in preparing these meals and the feedback received showed this had meant a lot to those receiving the meals. For example, one person had written, 'I can only say thank you so much for my lovely lunch on Christmas day, you will not know how much this meant to me…your staff were so kind to me, they checked I was well enough to eat and was warm and I had everything I could want for…you made Christmas special for me to know someone was

thinking of me'.

Good

Is the service responsive?

Our findings

People, their relatives and health and social care professionals told us that staff provided responsive care. For example, one person told us, "One just has to ask and your wishes come true".

At our last inspection we found that records relating to people's care and treatment had not always been suitably detailed. At this inspection we found that improvements had been made. People's care plans were now accessed via an electronic system. Staff used hand held tablets or computers to write, update and read people's care plans which covered a range of areas. Overall, people's care plans now provided a detailed record of their individual needs, how these were being met and the person's preferences and choices and daily routines. This enabled staff to have a good knowledge and understanding of the people they were supporting and helped to ensure people received care and support which was responsive to their needs.

There was evidence that people were receiving care that was responsive to their physical health needs. Staff were seen to be using pain assessment tools to help judge the severity and frequency of pain experienced by people who were not able to consistently express this due to cognitive problems. One person was prone to developing pressure ulcers. Their care plans included up to date and relevant risk assessments around contributing factors such as nutrition and mobility. There were photographs of the wound and up to date body maps in the care plan. The person was cared for on an air mattress, which was calibrated to their weight and regularly checked. Staff had referred the person to a tissue viability nurse for assessment and guidance and were following their advice.

The electronic care planning system contained a number of features that helped to effectively monitor and review risks to people's health and wellbeing. For example, key information about people's needs such as whether they had a do not resuscitate order, (DNACPR) or were at risks of falls or had allergies to medicines, were clearly displayed on banners on the hand held tablets used by staff. Staff were able to use the tablets anywhere in the home, allowing them to make contemporaneous updates to people's care plans. Each person's electronic dashboard noted the care tasks that had taken place and those that were due, such as helping people to reposition or to eat and drink. If these were not completed then this would be flagged. The registered manager was able to monitor each person's record more effectively and would be alerted, for example, if people's care plans had not been reviewed each month.

Most of the relatives told us they were kept fully informed about their family member's wellbeing, although one relative told us they would value more feedback about this and told us, for example, that they had not been told that their relative had been unwell. Also, whilst the service operated a key worker system, this relative was not aware who their family members key worker was and felt that perhaps this could have been communicated more effectively. Key workers develop a special relationship with the person by, for example, helping them settle when they first arrive at the home or co-ordinating their reviews and keeping their care plans up to date.

People took part in a range of activities. Three activities staff provided 72 hours of activities each week. The current activities were advertised and included talks, chair exercises, yoga, reminiscence afternoons,

quizzes, word games, massage, poetry readings and baking sessions and visits from therapy animals. People could also take part in flower arranging and a music club. In response to suggestions from people, a dance and dominoes league had just been started. If people wished, they were supported to visit the local pub. The home had a mini bus, able to take people requiring wheelchairs, and this was used to take people out to hospital appointments, shopping or to local places of interest. From our conversations with the activities team, it was clear that they knew people and their interests well. For example, we were told how one person loved motorbikes and another enjoyed military music. They told us how they played cards with one person which stimulated their use of arithmetic, which was a strength of theirs. During the inspection, people were enjoying a visit from a choir and a relative had come in to read to them. People had also been involved in creating a range of Easter decorations.

Following our last inspection, we made a recommendation that the provider look at ways of improving the activities provided for people living with dementia. Overall, some improvements had been made. The Nightingale Unit had recently been decorated with murals depicting café's and shops which staff told us they could use to engage and stimulate people.

The registered manager had helped staff set up a 'memory choir/ band'. The band was made up of people, their relatives and staff and used a range of instruments including tambourines, triangles, bells, drums, bongos, guitars, rain sticks, and whistles and tapping sticks. Some of the instruments had been made by people such as wash bottles with beans in them. The band had given two Christmas performances. The registered manager told us, "Tears were brought to my eyes when [person] was playing the drum to rhythm and singing to the music with a beautiful smile on his face. I only wish we could have bottled that moment". They told us relatives had also found it moving, "Seeing their family members 'come alive' to the sound of music and participating in the activity like they never had seen before". The money raised from this event had been split between two charities.

The provider was also funding a charitable film making organisation to come into the home to spend time with people living with dementia and their families, ultimately producing a free film about the life of the person. The registered manager told us the films would be used as a therapeutic tool to help the person feel proud of their lives, but also to stimulate conversation. It was also planned that staff would watch the films, helping them to see beyond the disease and instead see the person behind this.

Despite these improvements, we still received mixed feedback about the activities provided, some people were positive, for example, one person said, "There is plenty going on" and another said, "We have activities where someone does things, decorations for the season of the year, this afternoon we have someone coming to read to us". Others still felt that the activities provided did not need their needs. For example, one person told us they could be lonely at times, whilst another said they were fed up with watching old movies and wanted something more modern. Another person told us they could at times be "Bored to tears". The feedback from relatives was also mixed with one saying, "The activities have stepped up, there is something every day" but another saying, "The weekends can be dull".

We discussed this feedback with the registered manager. They told us that continuing to improve the activities remained a priority. Plans were now in place for at least one member of the activities team to work weekends and a survey had been undertaken to seek people's views about the type of activities they enjoyed most and which new activities they would like to see introduced. An activities co-ordinator was now in post and there were plans for them to undertake specialist training. The registered manager was confident that this was an area where improvements would continue and be led by people's interests and choices.

Information was provided in a format according to people's needs. For example, a compact disc had been produced for people to use to learn about the end of life care pathway that the home were implementing. Menus had been printed in blue for one person as this was more accessible for them. This helped to ensure that the service was complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

Technology was used to effectively to enhance care delivery, for example, pressure mats and door sensors were in use to reduce the risk of falls for people. A new call bell system had recently been installed which included individualised pendants which were linked to the person rather than to their room. So, for example, if the person fell in a corridor and pressed their alarm, staff could immediately know their location and attend to them. The home had Wi-Fi throughout and a digital assistant was being trialled by one person to help them to control aspects of their environment, such as switching lights or TV on. Streaming content and on demand movies and TV were available providing greater choice for people and services from a variety of nearby churches were also able to be streamed live into the home allowing people to enjoy these even if they were unable to attend in person.

Information about how to complain was readily available within the service and records showed that when issues or complaints had been raised, these were investigated promptly and appropriate actions taken to ensure similar complaints did not occur again.

Staff made every effort to make sure that people and those important to them were actively involved in expressing their wishes and making decisions about their end of life care. For example, senior staff had attended training on understanding the importance of having sensitive, open and honest communication with people and their relatives when discussing all aspects of end of life care. There was evidence that people were supported by staff that had the required skills to provide dignified and pain free end of life care. For example, the implementation of the Gold Standards Framework alongside other initiatives was to be a continued focus for the registered manager and provider throughout 2018 and was aimed at helping staff to continue to work effectively with the local hospice, GPs and other health care professionals to achieve robust advance care planning, develop staff skills and knowledge and allow people to die in a setting of their choice.

We were able to speak a little with one person who was nearing the end of their life, they were positive about the care and support they were receiving and their relative also told us they felt fully engaged in their family member's end of life care. The staff caring for the person were well informed and knowledgeable about the person's wishes also. The registered manager was aware of the importance of after death rituals for people from a variety of faiths and plans were in place to support these for one person using the service. A number of thank you cards received by the service spoke of the compassion with which the end of life care had been provided, for example, one had read, 'Thank you for taking such good care'. Feedback from health care professionals was also positive with one saying, "The staff seem well informed and treat each person with sensitivity and respect".

Good

Is the service well-led?

Our findings

People and their relatives told us the service was very well led. One person said, "The manager is very approachable and chatty. They're always out and about and available". A relative said, "I cannot commend [the registered manager] enough". Another relative said, "Since the last inspection, everything has improved, there is more staff training, the maintenance programme has been stepped up a bit, I'm happy with things".

One relative told us how the registered manager had gone the "Extra mile" to support them when a member of their family had been unwell. They told us how much they have valued this. They felt the registered manager had really demonstrated an awareness of the impact of mental health issues on their wider family.

Professionals were positive about the leadership of the home. One said, "The team is led and managed with compassion, competence and decisiveness and with a clear understanding of the needs of both residents and staff". Another professional told us, "Yes, I feel the manager leads the home well. She is always accessible when required. She contacts me on a regular basis to ensure that the practices are correct, takes on new initiatives….and ensures her home takes part in forums such as infection control".

Staff were positive about the leadership of the service and felt well supported in their roles. One staff member said, "We have really warmed to [the registered manager]… if you have a problem, you can go to her". Another staff member said, "I think things have really improved since the manager has been here" and a third said, "I think it's a very caring place and a lot of that comes from the manager".

Staff told us morale was good and that staff usually worked well as a team to meet people's needs. One staff member told us they had worked in a number of homes but that this one was the "Best". Some of the staff we spoke with raised concerns about levels of staff sickness being problematic but felt that this was now being addressed. Regular staff meetings were held which were well attended and included discussions on policies and procedures, safeguarding and job roles and responsibilities. Staff said they were encouraged to contribute ideas with one saying the registered manager "Likes out of the box thinking".

There were robust systems in place to monitor and improve quality and safety within the service. The provider used web-based incident reporting and risk management software to report, investigate and learn from incidents and accidents. Each month an analysis was made of the number of clinical incidents that had taken place within the service such as falls, pressure ulcers, hospital admissions, the number of people with unplanned weight loss and the number of infections. Remedial actions had been taken in response. For example, the registered manager had noticed that in February 2018, there had been an increase in falls, so it had been arranged for staff to attend falls awareness training. A range of audits were undertaken to monitor the quality and effectiveness of aspects of the service including care documentation, dignity, falls, information governance, infection control, and medicines management. The audits helped to identify what the service was doing well and the areas it could improve on. Clear action plans were drafted in response. The provider had recently strengthened its quality team and undertook weekly conference calls to discuss policy updates, clinical care and training. Mock inspections were undertaken to help identify any emerging risks or concerns in relation to all aspects of care delivery and members of the HMT board of trustees also

undertook visits to the service to assess the quality of care. This helped to ensure that the provider maintained oversight of the service.

The provider sought feedback from people, their relatives and from staff and used this to continually improve the service. 'Residents and relatives meetings' were planned in advance and gave people and their relatives the opportunity to hear about, and comment upon, important developments within the service. The provider undertook regular surveys. The most recent survey had been undertaken by an independent social research organisation and had resulted in a positive overall rating. Some areas were identified for improvement including staffing and activities and an action plan was being drafted to address these.

The service played a role in the local community. For example, staff delivered meals to people living alone to help prevent isolation. The home's staff laundered the church linen for both Romsey Abbey and the local Catholic church. People, their relatives and staff took part in a memory walk around the local community twice a month organised by the local dementia action group. This started and finished at the home and included a hot drink and a quiz based upon what people had seen on the walk, making the event a social occasion. Plans were also being made to extend a welcome to groups of children from the local nursery to spend time with people.

The registered manager was committed to ensuring that they continued to develop their own skills and knowledge in order to continue to deliver a high quality service. For example, they had recently attended the Future of Care conference and had completed the Care Home Leadership development programme. The registered manager and provider had a clear vision for the service. Their aims and objectives for the next five years included implementing a five year dementia care strategy. To support this, a new deputy manager had been recruited with specialist knowledge of dementia care. The unit lead of the Nightingale Unit was to undergo training to become an Admiral nurse and was planning to enrol on a degree in dementia care. Admiral nurses are specialist dementia nurses who give expert practical, clinical and emotional support to people and families living with dementia. The provider was also committed to continuing to build upon their links with the local community and to continuing to fund and take part in research projects such as the care home band as part of its' dementia strategy.

The registered manager demonstrated a passion and enthusiasm for their role and they were committed to improving their own skills and knowledge and those of their staff team. Their commitment to the service, the people in their care and to the staff team was clear to see and they had fostered a homely, friendly and person centred culture within the home based upon values which included honesty, inclusion and equality for each person and staff member. The positive atmosphere of the home was commented on by one professional who told us, "There is a warm, friendly atmosphere to the House which is greatly helped by the spacious design of the building itself and its on-going maintenance, by good involvement with the local community in regular and one-off events and most importantly by the quality of a dedicated staff team who see that their work is vocational and worthwhile". Throughout the inspection, the registered manager welcomed feedback and any recommendations or comments we made were acted upon promptly, showing a commitment to quality and to ensuring that people were receiving the best care possible.